F1
September 4, 1997

U.S.AGENCY FOR
INTERNATIONAL
DEVELOPMENT

Dear Colleague:

I am pleased to announce the FY 1998 PVO Child Survival Program funded by the Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation (BHR/PVC). The Program strives to enhance the participation of U.S.-based private and voluntary organizations(PVOs) to reduce infant, child and maternal mortality in developing countries, and to strengthen the organizational and technical capacity of PVOs in these areas.

Special consideration will be given this year to programs which partner with local NGOs, community-based organizations and/or local and district Ministries of health and focus on increasing their capacity in implementing child survival and health programs. All programs should also work to achieve sustainable benefits which will continue after the USAID funding is over.

BHR/PVC has continued the two major changes introduced in last years RFA. First, the new grant categories, Entry and Mentoring, which assist new PVOs to enter the CSGP. We encourage PVOs with experience in the CSGP to consider partnering with other PVOs in mentoring relationships. Second, the 50% cost-share requirement for programs in countries where BHR/PVC has previously funded a PVO for two or more cycles, in order to promote long term financial sustainability.

The overall priorities for the FY 1998 PVO Child Survival Grants are for programs that:

a.Are carried out in countries and/or sites with high under-five mortality rates, and address the major causes of this mortality in the target location. A special emphasis is placed on eligible countries with under-5 mortality rates more than 100 deaths per 1,000 live births. (See list of eligible countries)

b.Focus on child survival strategies that have a high potential for sustainability, and given the capability of the applicant and its partners, are technically and logistically deliverable at reasonable costs.
c.Form partnerships with local non-governmental organizations (NGOs) and other local organizations, including community-based groups and local health authorities.

d.Plan for the financial and institutional sustainability of the program benefits after the end of the grant.

e.Focus on viable and innovative strategies, methods, or materials, which may be used in the future, or are applicable on a wider scale, for implementing child survival activities; and

f.Contribute to the intermediate results of the BHR/PVC strategic plan.

Full details about the program's purpose and scope, as well as the eligibility requirements and the review process, are described in the enclosed Request for Applications (RFA). Applications are due at BHR/PVC by Friday, December 5, 1997.

BHR/PVC looks forward to receiving and reviewing many fine applications in this cycle. I personally look forward to the opportunity to collaborate with you as a partner in this long-standing and highly effective program.

Sincerely,

John P. Grant
Director
Office of Private and Voluntary Cooperation
Bureau for Humanitarian Response

Enclosures: FY98 RFA and Annexes

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

REQUEST FOR APPLICATIONS (RFA)
938-98-A-0500-14

1998
PVO CHILD SURVIVAL GRANTS PROGRAM

APPLICATION CLOSING DATE: DECEMBER 5, 1997

BUREAU FOR HUMANITARIAN RESPONSE
OFFICE OF PRIVATE AND VOLUNTARY COOPERATION
ABBREVIATIONS AND ACRONYMS

AIDSAcquired Immune Deficiency Syndrome
ARIAcute Respiratory Infection
BHRBureau for Humanitarian Response
CDDControl of Diarrheal Disease
CHWCommunity Health Worker
CSChild Survival
CSGPChild Survival Grants Program
CSSPChild Survival Support Program
DCMDiarrhea Case Management
DIPDetailed Implementation Plan
DPTDiphtheria, Pertussis, and Tetanus
EPIExpanded Program in Immunization
HISHealth Information System
HIVHuman Immunodeficiency Virus
HQHeadquarters
IDAIron Deficiency Anemia
IMCIIntegrated Management of Childhood Illnesses
INACGInternational Nutritional Anemia Consultative Group
IRIntermediate Result
IVACGInternational Vitamin A Consultative Group
JHUJohns Hopkins University
LAMLactation Amenorrhea Method
MOHMinistry of Health
MNCMaternal and Newborn Care
NGONon-governmental Organization
NICRANegotiated Indirect Cost Rate Agreement
OPOffice of Procurement
ORSOral Rehydration Solution
ORTOral Rehydration Therapy
PAHOPan American Health Organization
PCMPneumonia Case Management

PVOPrivate Voluntary Organization
PVCOffice of Private and Voluntary Cooperation
RFARequest for Application
SCMStandard Case Management
SOStrategic Objective
STISexually Transmitted Infection
TBA Traditional Birth Attendant
UNICEFUnited Nations International Children's Emergency Fund
USAIDUnited States Agency for International Development
WHOWorld Health Organization
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REQUEST FOR APPLICATIONS (RFA)
938-98-A-0500-14 Issuance Date: September 4, 1997
PVO Child Survival Grants Program Closing Date: December 5, 1997

A.APPLICATION PREPARATION AND SUBMISSION INSTRUCTIONS

USAID/BHR/PVC is seeking applications for funding from U.S. Private Voluntary Organizations for programs meeting the requirements of this RFA. We are issuing this RFA in anticipation of funds to be made available to BHR/PVC for this purpose. However, while BHR/PVC expects such funding to become available, there can be no assurance that this will be the case and issuance of this RFA does not constitute an award commitment on the part of the U.S. Government. Further, the U.S. Government reserves the right to reject any or all applications received.

If your organization decides to submit an application for funding from the BHR/PVC PVO Child Survival Grants Program, you must submit a separate application for each proposed country program. All applications should be submitted with the name and address of the applicant and RFA Number inscribed thereon to:

Mailing Address:Hand Carried/Courier Service Address:
Ms. Sarah HurstMs. Sarah Hurst
USAID/BHR/PVCUSAID/BHR/PVC
7th FloorRonald Reagan Building
Washington, D.C. 205237th Floor
1300 Pennsylvania Ave. N.W.
Washington, D.C. 20004-3002

To facilitate duplication for review purposes, we ask that applicants submit a version on diskette, WordPerfect 5.1/5.2, an unbound, single-sided original,

and two (2) bound, double-sided copies of the application (each with a complete set of attachments - PLEASE DO NOT SUBMIT PLASTIC FOLDERS WITH UNBOUND COPIES).

To be considered for the review process, applications are due on December 5, 1997.

It is the responsibility of the PVO to send one copy of its Child Survival application to the USAID Mission in the country where the activities are being proposed when it submits its application to BHR/PVC. Applications should be received by the USAID Mission no later than 12/19/97.

Applicants must submit with the original of their application, the Self-Certifications pertaining to compliance with applicable federal and USAID accepted policies for personnel, travel, and procurement systems. If the applicant has not yet completed these certifications, it may obtain a self-certification package from:

Mr. Barry Knauf
Contracting Officer
USAID/M/OP/PS
Ronald Reagan Building
1300 Pannsylvania Ave., N.W.
Washington, D.C., 20004-3002

In accordance with the Paper Reduction Act, all applications shall be legible, on standard, letter-size paper (8 ½" x 11"). Applicants are asked to limit the body of their application to 40 pages or less, and all attachments should be limited to 25 pages or less. The body of the application includes the executive summary, organizational background, the proposed program, and the work plan. Pages beyond the forty (40) page limit will not be considered in the review process. Please avoid using this space to "educate the reader about child survival." The application will be read and evaluated by specialists in child survival and public health.

Type face/characters, including those used in tables, must be no smaller than 10 characters per inch (cpi) or 12 points. "Cpi" is a fixed pitch spacing per inch. Point refers to the measurement of proportional spacing of scaleable fonts. If you have doubts about the font you are using, hold a ruler under a line and count the characters in an inch. Ten cpi is generally 12 points. Please refer to your word processing manual for a complete explanation.

All Attachments and/or Supplementary documents must be in English or with an English translation.

The preferred method of distribution of USAID procurement information is via the Internet or by request of a solicitation of a 3.5" floppy disk (WordPerfect 5.1/5.2 format). This RFA can be

downloaded from the Agency web site. The Worldwide Web address is http://www.info.usaid.gov. Select Business and Procurement Opportunities from the home page, then USAID Procurements." On the following screen, select "Download Available USAID Solicitations." The RFA can also be downloaded via Anonymous File Transfer Protocol (FTP). The FTP address is FTP.INFO.USAID.GOV. Logon using the user identification of "anonymous" and the password is your e-mail address. Look under the following directory for the RFA:pub/93880500/93880500.rfa. Receipt of this RFA through the INTERNET
must be confirmed by written notification to the contact person noted above. It is the responsibility of the recipient of this solicitation document to ensure that it has been received from INTERNET in its entirety and USAID bears no responsibility for data errors resulting from transmission or conversion processes." If not downloading from the INTERNET, when requesting solicitation include either a 3.5" floppy disk (WordPerfect 5.1/5.2 format) or self-addressed labels and send to the address under Article A, Mailing Address.

Any prospective applicant who has a question concerning the contents of the RFA should submit the question in writing to Ms. Sarah Hurst (fax (703) 351-0212) before October 15, 1997, after which BHR/PVC is relocating, and communication may be unreliable. Any additional information regarding this RFA will be furnished through an amendment to the RFA..

B.OVERVIEW OF THE OFFICE OF PRIVATE AND VOLUNTARY COOPERATION

USAID's Office of Private and Voluntary Cooperation (BHR/PVC) is the focal point for the Agency's partnership with U.S. Private Voluntary Organizations (PVOs) and Cooperative Development Organizations (CDOs). BHR/PVC's competitive grants programs provide direct support to the U.S. PVOs and their local partners to address critical needs in developing countries and emerging democracies. These programs include: Matching Grants, Child Survival Grants, Cooperative Development grants, the Farmer-to-Farmer Program, the Development Education Program, and Ocean Freight Reimbursement. BHR/PVC is responsible for registering U.S. PVOs for the Agency, and is a central contact point in USAID for information on PVO capabilities and programs. The Office is also a key participant in the development of Agency policies and procedures that affect these U.S. organizations.

Each USAID operating unit is guided by its own Strategic Plan that in turn contributes to the Agency's Sustainable Development Goals. BHR/PVC's Strategic Plan outlines its program directions and provides a framework for all the grant programs funded and administered by the Office. It articulates the specific objectives, strategic approaches and performance measures that will guide the Office's work through the year 2002. PVC's Strategic Plan was developed through a collaborative consultation process involving all PVC staff members, selected representatives from other USAID offices, and many of PVC's partners in the PVO

community.

PVC's Strategic Objective (SO) is to "increase the capability of PVC's PVO partners to achieve sustainable service delivery." This SO builds upon PVC's expertise and historical experience working with U.S. PVOs and CDOs, and reflects its primary mission of strengthening the technical and managerial capacity of these partners to successfully contribute to international development. PVC is uniquely positioned within USAID to build institutional capacity. Over the years, PVC's grants have helped many organizations strengthen their institutional capacities and improve their ability to implement operational programs that USAID and other donors' support.

PVC's SO promotes three distinct elements -- capacity-building, service delivery, and sustainability -- all of which are critical for ensuring the significant impact of the work of PVOs on international development problems. The SO reflects PVC's commitment that improvement in capability will result in tangible improvements in services to people in developing countries and that the benefits of the PVO programs will be sustained over the long term.

Achievement of PVC's SO will lead to its goal of achieving sustainable development in priority sectors in which USAID in focusing its efforts: Economic Growth; Population and Human Health; Environment; Democracy; Basic Education and Training; and Crisis Avoidance, Mitigation and Relief. PVC's Strategic Plan recognizes that the capacity of PVOs to partner effectively with local organizations will achieve another important outcome: NGO and other local partners strengthened. The Office has incorporated this critical, complementary objective in its plan as a Sub-Goal.

As the objectives of PVC's Strategic Plan indicate, the Office views capacity building within the institutions it supports, not as an end in itself, but as a means of ensuring that its grant programs result in goods and services provided on a sustainable basis to the people of the countries that USAID assists. The wording of its SO emphasizes the "achievement of sustainable service delivery." This reflects the fact that some of PVC's partners still deliver goods and services directly, while others are instead focusing their efforts on the development of strong local capacity for providing these services. Both types of programs contribute to the achievement of PVC's Strategic Objective.

To achieve its Strategic Objective, PVC has identified five Intermediate Results (IRs) that cut across all of the grants programs supported by PVC:

-- Operational and Technical Capacity of U.S. PVOs Improved

-- Strengthened Partnership between USAID and U.S. PVOs

-- Strengthened U.S. PVO and NGO Partnership

-- Improved Mobilization of Resources by PVC's PVO Partners

-- U.S. Public Awareness Raised

Given the importance of these results to PVCs strategic plan, all applicants this year are asked to address the question of how their proposed program will contribute to PVC's Strategic Objective and these five intermediate results.

This year's program places special emphasis on strengthening partnerships between U.S. PVOs and local NGOs and other local groups, to build their capacity as effective development organizations. A second key area of emphasis is the adoption of creative approaches to resource mobilization and other strategies to promote long term financial sustainability. A third critical priority is a focus on achieving tangible and demonstrable results and effective performance monitoring.

PVC has selected a set of performance indicators to measure progress toward each of its key objectives (IRs and SO). The Office is in the process of collecting baseline data and establishing targets for each of the performance indicators. Progress toward PVC's targets are reported to the Agency on an annual basis.

C.THE PVO CHILD SURVIVAL GRANTS PROGRAM (CSGP)

C.1.Program Goals and Objectives

The PVO Child Survival Grants Program (CSGP) is a competitive grants program funded and administered by the Bureau for Humanitarian Response (BHR), Office of Private and Voluntary Cooperation (PVC). The program is open to all U.S.-based Private and Voluntary Organizations (PVOs), registered with USAID, that engage in community health care programming as part of their international development efforts.

The two objectives of the CSGP are to:

aMeet the critical health needs of infants, children under five years of age, and mothers in those developing countries with high infant, child and maternal mortality rates; and

b. Improve the capacity of U.S.-based PVOs and their local partners to
carry out effective child survival programs.

Consistent with PVC’s Strategic Objective, described above, the PVO CSGP contributes to the “increased capability of PVC’s PVO partners to achieve sustainable service delivery.” The CSGP focuses on strengthening the ability and the capacity of PVO staff to design, manage and evaluate child survival activities, to fund and manage a

child survival and health portfolio, to engage in long-term partnerships with NGOs, and to disseminate information on PVOs' comparative advantages in child survival & health activities. This program supports institutional strengthening of U.S. PVO headquarters and field staff and their local partners, enhancing their capacity to reduce infant, child, and maternal mortality.

Beyond strengthening the ability and capacity of the U.S. PVOs, which contributes to PVC's Strategic Objective (SO), experience with this program has shown a contribution to all of PVC's Intermediate Results. The partnerships between USAID and the U.S. PVOs have become more collaborative both with PVC and with the USAID field missions. While this program was developed to strengthen the skills of US PVOs, all programs require partnering with local NGOs or other local organizations, and thus CSGP expects that the US PVOs will transfer technical and managerial skills to their partner organizations. Through this program, the partnerships between the U.S. PVOs and their local counterparts are clearly defined and more productive. The CSGP requires sharing resources to reach a common goal. The PVOs participating in this program have contributed significantly to its success over the years, with both financial and human resources. The rigorous requirements of this program have enabled our partners to document their successes and more vividly convey to their supporters the work they have accomplished in developing countries.

In striving to meet its strategic objective, BHR/PVC targets specific activities for PVOs receiving funding under the CSGP. PVOs receive individualized technical assistance in project design and implementation, and annual technical reports which contain state-of-the-art information on child survival interventions. They are invited to take part in training activities focusing on measuring, documenting and disseminating results and specialized workshops and conferences for personnel at the country, regional and headquarters level. BHR/PVC also uses the analysis of the Detailed Implementation Plan (DIP) as a learning experience by inviting the PVO to participate.

C.2.Program Priorities

BHR/PVC strives to invest USAID resources in well designed, technically sound, cost-effective programs that focus on activities and strategies through which programs may expect to make the greatest impact in reducing under five and/or maternal mortality in a sustainable way. Priorities for the FY 1998 PVO Child Survival Grants Program are for programs that:

a.Are carried out in countries and/or sites with high under-five mortality rates. A special emphasis is placed on eligible countries with under-5 mortality rates more than 100 deaths per 1,000 live births. (See list of eligible countries)

b.Focus on child survival strategies that have a high potential for sustainability, and given the capability of the applicant and it

partners, are technically and logistically deliverable at reasonable costs.

c.Form partnerships with non-governmental organizations (NGOs), community-based groups, local health authorities and/or other U.S.-based PVOs in the design and implementation of the program.

d.Plan for the financial and institutional sustainability of the program benefits after the end of the grant.

e.Focus on viable and innovative strategies, methods, or materials, which may be used in the future, or are applicable on a wider scale, for implementing child survival activities; and

f.Contribute to the intermediate results of the BHR/PVC strategic plan.

Child Survival activities currently supported through the CSGP include:

♦immunization;
♦nutrition, including micronutrient promotion or supplementation;
♦breastfeeding;
♦control of diarrheal disease;
♦pneumonia case management;
♦control of malaria;
♦maternal and newborn care;
♦child spacing; and
♦prevention of Sexual Transmitted Infection and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), where appropriate.

Other infectious disease activities may be appropriate in certain sites.

C.3.Eligibility Criteria

All applications will be reviewed for eligibility. (See Article C.3. Eligibility Criteria).

a.Organization Criteria - To be eligible for funding under the BHR/PVC Child Survival Grant Program, an organization must:

1.Be a U.S.-based PVO, currently registered with USAID at the time of submission;

2.Receive at least 20% of its total annual financial support for its international programs from non-U.S. government sources (or fall within Congressionally-mandated guidelines);

3.Contribute, from its non-U.S. Government resources, at least 25% of the total cost of the proposed program (for PVOs proposing a

program in a country where they have been funded for two or more funding cycles, a 50% cost-share is required);

4.Have experience implementing community health related programs in developing countries; and

5.Have a formal presence in the country where a child survival program is proposed documented by a signed agreement with the host government prior to the award date. Previous health program experience in the target country is not required.

b.Program Criteria - Proposed programs must meet the following criteria to be considered for funding:

1.Be proposed in a country or countries:
-On the eligible country list;
-Where the PVO does not have an active BHR/PVC Child Survival Grant. A PVO may not have more than one program in a country at any one time;

2.Be consistent with USAID's country specific program priorities in the population and health sector, document consultation with the USAID Mission, and have the USAID Mission's approval for the proposed program;

3.Be consistent with the national policies in child survival in the targeted country;

4.Involve a partnership with a local NGO or other local organization. BHR/PVC requires PVOs to form partnerships with local non-governmental organizations (NGOs), community-based groups, local health authorities, and/or other U.S.-based PVOs. All applications must be prepared in collaboration with all pertinent partners in the proposed program site;

5.Assign at least one public health professional at the PVO’s U.S. headquarters to be responsible for backstopping CSGP activities, and one full-time staff person, with substantial experience in implementing community health or child survival programs, located at the proposed field site.

C.4.Eligible Countries

Under-5
Mortality Rate*AFRICAASIA, NEAR EAST
and Central AsiaLATIN AMERICA & THE CARIBBEAN>100/1,000
live birthsAngola
Benin
Eritrea
Ethiopia
Ghana
Guinea
Madagascar
Malawi

Mali
Mozambique
Rwanda
Senegal
Tanzania
ZambiaBangladesh
India
Nepal

Bolivia
Haiti70-100/ 1,000Kenya
Tajikistan50-69/1,000South AfricaEgypt
Morocco
PhilippinesGuatemala
Nicaragua
Peru< 50/1,000

Ecuador
El Salvador
Honduras
*The State of the World's Children, 1997, UNICEF.
C.5.Award Categories

USAID-BHR/PVC is seeking applications for four categories of funding: entry, new, follow-on, and mentoring partnership programs. All categories are competitive. PVOs may apply for funding for programs in more than one category. However, USAID will not award concurrent Cooperative Agreements to a PVO under both the Entry CA and New Program categories.

Owing to limited resources, BHR/PVC will support funding of no more than three Child Survival Cooperative Agreements to any one PVO.

a.Entry Programs (2-Years)

BHR/PVC is actively seeking new PVO partners in the PVO Child Survival Grants Program, to develop their abilities to plan and implement successful child survival programs in developing countries. BHR/PVC will consider Cooperative Agreements to organizations that have never received a CA from the CSGP, but that have some experience in implementing community health programs in developing countries. Each two-year Cooperative Agreement will be awarded for up to $400,000.

During the two-year period, PVO recipients of these CAs will be expected to complete an in-depth analysis of the current health situation in the proposed area, establish strong partnerships with local counterparts, jointly design a program, and initiate activities. This analysis should include the current state of the health infrastructure, the current health status of the beneficiary population, the knowledge, practices, and beliefs of the target population, and all other information that would help the PVO develop a child survival program for the proposed site. Upon completion of the analysis, the PVO shall collaborate with

appropriate local partners to design a program and initiate a limited set of activities that could be scaled up.

The CSGP will be available to assist the PVO during the life of the Entry Agreement with specified technical assistance and training.

b.New Programs (4-Years)

BHR/PVC will support up to $1,000,000 each for a new CA program in eligible countries. Applications for this award category are welcomed from ALL interested registered U.S. PVOs.

c.Follow-on Programs (4-years)

PVOs with currently funded Child Survival programs scheduled to end in FY 1998 may apply for funding for follow-on programs for the same activity, or to further develop the existing program. However, the CSGP can not support amendments to existing awards or follow-on awards for the same activity beyond 10 years of the original award date.

BHR/PVC will support up to $1,000,000 each for a follow-on program. Applications for all follow-on programs need to include a clear plan for sustainability and transition to other funding.

In order to demonstrate progress towards long term financial sustainability, applications for new and follow-on program in a country where BHR/PVC has funded a PVO already for two or more CA cycles require a cost-share of 50% of the total program costs.

d.Mentoring Partnerships Programs (4-Years)

Under this funding category, USAID will support up to $1,500,000 for each successful application. BHR/PVC solicits applications for innovative partnership programs between U.S. PVOs that are current or past recipients of BHR/PVC PVO Child Survival Cooperative Agreements/Grants, and other U.S. PVOs with international health and development experience in areas other than community-based child survival that have not received funding under this program. This category of funding is intended to encourage PVOs less experienced in community child survival programs to engage in these activities. At least one of the organizations must demonstrate a current, active presence in the target country.

A single award will be made to one recipient. The recipient may be either the mentor or mentored organization, with the partner as a sub-recipient. The application should propose the structure that the partner organizations have determined meets their respective needs.

To help PVOs contact others that might be interested in a partnership, attached is a list of all organizations requesting this RFA as of date of issue. (See Annex E)

C.6.Program Restrictions

The PVO Child Survival Grants Program does not support, with USAID funds, the following types of activities: income generation, literacy training, water and sanitation, or activities focused only on adolescents. If the PVO demonstrates that these activities are critical to achieve the program objectives, the PVO or other sources may fund them as an appropriate cost-share.

Programs, whose primary purpose are either: research; equipping hospitals, orphanages or other residential facilities; medical care in hospitals; construction; manufacturing of pharmaceutical, bednets, or other health aids; evacuation of children to the U.S. for medical treatment; emergency relief activities; or adoptions are beyond the scope of the CSGP and will not be reviewed for funding.

C.7.Requirements for Funded Programs

USAID will award a separate cooperative agreement for each country program selected. After the award, each program will be required to:

a.conduct a baseline and final self assessment of the PVO's organizational capacity at headquarters and in-country;

b.conduct a baseline and final assessment to measure program impact;

c.submit a life of program (LOP) work plan, called a Detailed Implementation Plan (DIP), within six months of the program start date, following guidance from USAID (draft guidelines for DIPs are in Annex C of this RFA); and

d.conduct evaluations, following guidelines provided by BHR/PVC.

The awards made pursuant to this RFA will be subject to the requirements of 22 CFR Part 226 "Administration of Assistance Awards to U.S. Non-Governmental Organizations," and the applicable Standard Provisions for U.S., Non-Governmental Grantees. A copy of the standard provisions is attached for ease of reference (see Annex D).

Prior to any award decision, the Agreements Officer may request a pre-award survey of the applicant organization(s) to assess financial management capabilities and to confirm all factors of eligibility for this program.

C.8.Substantial Involvement

Cooperative Agreements are conditional gifts that have substantial involvement of USAID in the implementation of the program. BHR/PVC will be substantially involved during the period of the cooperative agreement. Specifically, the CSGP Project Officer will provide:

a.Approval of the Detailed Implementation Plan (DIP), and any subsequent revisions, submitted to USAID/BHR/PVC within six months of the award. PVC staff and other technical specialists will review the DIP and meet with the PVO to discuss strengths and weaknesses. Substantial changes, resulting in any revisions to specific activities, locations, beneficiary population, international training costs, international travel, indirect cost elements, or the procurement plan, may require a modification to the cooperative agreement by the Agreement Officer.

b.Approval of key personnel and any subsequent changes in the positions during the life of the award. The PVO are required to request the approval of the USAID Project Officer for the following personnel: Headquarters Technical Backstop, Field Program Manager, and Evaluation Team Leaders.

c.USAID involvement in monitoring progress toward the achievement of program objectives during the Cooperative Agreement. BHR/PVC will provide written guidance for annual reports and midterm and final evaluations.

D.EVALUATION CRITERIA AND REVIEW PROCESS

D.1. Evaluation Criteria

Evaluation CriteriaMaximum Points for CA Type(2) Proposed Budget
- appropriate use of USAID funds
- appropriate use of Match/Cost Sharing funds
- budget reflects local partnering
Entry: 10
New: 10
Follow-on: 10
Mentoring: 10(4) Description of Organization(s)
- application's fit with PVO strategic plan
- strategy to apply lessons learned
- valid rationale for expanding into CS (new PVOs)
- previous PHC experience
- appropriate plans for transferring skills to partners
- identification of & plans for challenges
- status/agreements/relationships in country
- personnel: linkages, qualifications, % time
- fit of this application to others
- agreement & roles of PVOs (Mentoring only)Entry: 20
New: 10
Follow-on: 5
Mentoring: 15(5a) Site Selection and Analytical Basis
- high mortality country
- appropriateness of program site
- analytical basis for proposed approaches, interventions, & strategies
- sound reason for 3rd cycle funding
- consistency with Mission and government plans

- if applicable, builds on previous in-country experienceEntry: 10
New: 10
Follow-on: 10 Mentoring: 10(5b) Program Design
- appropriateness & technical soundness of overall design, strategies, collaboration
- programs relation to health activities/facilities
- inclusion of new methods, strategies, materialsEntry: 10
New: 10
Follow-on: 10
Mentoring: 10(5c) Child Survival Interventions
- realistic objectives, results, target groups
- appropriate strategies, methods, activities
- essential elements addressed for each intervention
- appropriate integration with existing activities Entry: 5
New: 10
Follow-on: 5
Mentoring: 5(5d) Management Plan
- strong management structure
- adequate HQ plan for monitoring field
- staff qualifications in relation to responsibilities
- staff responsibilities in relation to # and types of activities
- roles of & support to committees & groups
- sensible rationale for working with workers & communities
- feasible & adequate training plans
- plan for sustaining volunteer participationEntry: 5
New: 5
Follow-on: 5
Mentoring: 10(5e) Work Plan
- feasible work plan for LOP
- feasible action plan for first yearEntry: 5
New: 5
Follow-on: 5
Mentoring: 5(5f) Performance Monitoring and Evaluation
- realistic plans for assessments, surveys and studies
- appropriate strategies, methods, & tools proposed to monitor performance, quality and coverageEntry: 20
New: 10
Follow-on: 5
Mentoring: 10(6) Partnerships and Capacity Building
- adequate plans to build strong partnerships with NGOs and local government
- verifiable support from proposed partners
- plans for capacity building of local partnersEntry: 5
New: 10
Follow-on: 15
Mentoring: 10(7) Sustainability
- realistic definition and plans
- realistic technical sustainability
- realistic community contribution
- cost-effectiveness
- realistic financial sustainability plans
- realistic devolution strategies for 3rd cycle applicantsEntry: 5
New: 10

Follow-on: 15
Mentoring: 5(8) Past Performance (if applicable)
- past adherence to the terms & conditions of previous awards, both technically and administratively
- performance documented in past evaluations
- how recent recommendations were addressedNew: 5
Follow-on: 10
Mentoring: 5(9) BHR/PVC Strategic Plan
- contribution to PVC intermediate results
- PVO conveyance of results to publicAll Applications: 5Total score converted to percent of maximum Maximum: 100%

D.2.Review Process

All applications received in accordance with submission instructions cited on the
cover page, which meet the eligibility and program requirements, and conform to the application instructions, will be reviewed by a panel of USAID reviewers in strict conformity with the evaluation criteria set forth above. This team will consist of appropriate staff from BHR/PVC, USAID Missions, USAID Regional Bureaus, and other USAID offices with related interests and expertise. BHR/PVC will distribute copies of each application to all reviewers, except USAID Missions. Applicants are responsible for providing a copy of the application to the relevant USAID Mission.

USAID Missions will review applications and send their review and comments directly to BHR/PVC. Their review will be a critical consideration in funding decisions. To ensure that proposed programs adequately support achievement of USAID Mission objectives, we strongly urge that applicants discuss their ideas and planned programs with the USAID program officer and technical officer in the targeted country before preparation and/or submission of an application. The PVO should include evidence of this consultation in the funding application.

The budget narrative of all applications under consideration for award will be reviewed for what is necessary and reasonable to support the project.

Upon completion of its initial review of applications, BHR/PVC may, as it deems necessary and appropriate, conduct written and/or oral discussions with those applicants whose applications remain in the competitive range. The decision to conduct such discussions should not be considered to reflect a final decision about which organizations will receive an award, but rather as part of the evaluation process.

The review process of the CSGP applications will take approximately two to three months, after which BHR/PVC will prepare a recommendation for approval. The USAID Office of Procurement will

negotiate with those PVOs with recommended programs, and make awards before September 30, 1998. USAID however, reserves the right to fund any or none of the applications submitted.

D.3.Negotiation and Award

Authority to Obligate the Government - The Agreement Officer is the only individual who may legally commit the Government to the expenditure of public funds. No costs chargeable to the proposed Cooperative Agreement may be incurred before receipt of either a fully executed Cooperative Agreement or a specific, written authorization from the Agreement Officer.
If recommended for an award, it is the responsibility of the Agreement Officer to make responsibility determination regarding your organization. Budget negotiations will be conducted using OMB Cost Principles and other USAID Standards that may apply, entailing a breakdown of each line item, and reduce to writing all understandings between USAID and the Recipient. The Agreement Officer may request from prospective Recipients additional information regarding the budget figures.

E.APPLICATION GUIDELINES

No specific format has been prescribed for the application. However, applicants are encouraged to respond to the corresponding sections of the application guidelines below, ensuring that all review criteria are addressed. All annexes should be clearly marked and listed in the table of contents.

E.1.USAID Form 424

USAID Form 424 is the standard form used by applicants as the required face sheet for applications submitted for Federal assistance. Detailed instructions for completing these forms for this program are included in Annex A.

E.2.Budget and Budget Narrative

USAID Form 424A is the standard form used by applicants for presenting overall budget information.

The budget narrative should fully explain the line item costs for both the federal (USAID) and non-federal (PVO cost-share) funded portions of the budget so that the Project Officer and the Agreement Officer can easily verify your cost based on the calculations shown in the narrative.

The 424A contains 11 Object Class Categories, including the Total. Each Object Class Category (cost element) listed in Block 6 of the SF424A has a notation next to it which indicates which budget cost element into which it will normally fall. [For example: Personnel (1) - which shows that Object Class Category 6a. Personnel would be in the "Program" cost element]

Recipient costs proposed for Training and Subgrants must be included in the "Other" Object Class Category. The costs proposed for Training and Subgrants must be itemized in the budget narrative explanation of the Object Class Categories so that they may be negotiated and included in the appropriate Cost Elements in the Cooperative Agreement Budget.

Note:Cooperative Agreement Budget: The budget in the award document will be based on the 424A budget and budget narrative submitted by the PVO, and will normally have only 4 cost elements. The budget will be set up as follows:

Cost ElementAmount

(1)Program (or output)* -
(2)Training -
(3)Procurement -
(4)Indirect Costs (overhead) -
Total -

(1) Program: If the Recipient's application has more than one output or program, each output/program would be listed separately. Ordinarily, each instrument supports only one output/objective. Subgrants may be included in Line Item 1.
(2) Training: Participant training may be included in Line Item 2 of the award.
(3) Procurement: The Procurement cost element includes anything the Recipient has to contract out for such as consultant services, subcontracts (NOT subgrants), supplies, equipment, evaluation costs that are subcontracted, etc.

a.Headquarters Costs

For all program categories, PVOs should include budget detail separately for the headquarters and for the field program. Up to 15 percent (15%) of the proposed direct costs of a budget may be allocated to the PVO's U.S. Headquarters cost (or JOINT headquarters in the applications for mentoring partnerships). This amount may be exceeded (up to a total of 20% of the proposed direct costs) but the application MUST clearly show how any additional funds will improve the PVO's institutional capacity for child survival programming. This does not interfere with established cost rates.

b.Cost-Share

The Recipient agrees to expend an amount not less than 25% of total Federal contribution. Cost sharing contribution will meet the criteria as set out in 22 CFR 226. Applicants should refer to Section 226.23. All criteria must be met and discussed in the budget narrative.

c.Restricted Goods

BHR/PVC will not authorize the use of USAID funding for:

-agricultural commodities;
-non-US manufactured motor vehicles, including motorcycles, mopeds, and mobylettes;
-pharmaceuticals;
-seeds and pesticides;
-rubber compounding chemicals & plasticizers;
-used equipment.
-U.S. Government-owned excess property, or
-fertilizer.
BHR/PVC does NOT seek waivers for the purchase of non-U.S. motor vehicles, pharmaceuticals, used equipment, seeds or pesticides. The applicant should consider funding such commodities with the non-federal portion of the budget.

The Recipient is expected to use its own private cost-share-matching funds for all procurement of nonexpendable property estimated at over $5000 per unit and for non-U.S. procurements.

d.Procurement Plan

For all grant categories include a procurement plan. Read carefully the guidance on Equipment, Supplies, and Other, including the sections on restricted goods, in Annex A.

SPECIAL REQUEST

USAID/BHR/PVC may have the opportunity to receive supplemental funding for micronutrient, HIV/AIDS, Polio/EPI or other infectious diseases. To the extent possible, please estimate the overall cost of these interventions, if appropriate for your program. This will position PVC to request these funds.

E.3.Executive Summary (1-2 pages)

There is no prescribed format for the Executive Summary, however, it should briefly describe the proposed program, including: program location; estimated under five mortality rate in the area; goals and expected impact of the program; estimated numbers of potential beneficiaries; program interventions and strategies; How the local partners participated in the development of the application; how the program will enhance the PVO's, local partners and collaborating agencies child survival programming capacity; local partners and collaborating organizations; and capacity building and sustainability strategies.

Please identify the grant category, and include the names of all authors of the application. Include the name and position of the local USAID Mission representative with whom the proposed program has been discussed.

E.4.Description of the Organization(s) (1-2 pages)

(Under the Mentoring category please provide this information for each PVO partner.)

♦Briefly describe the U.S. PVO, such as its general purpose, annual budget, major sectors of involvement, and methods of operation;

♦Briefly describe how the application(s) fits into the PVO's overall strategic plan, and how the organization will apply lessons learned from participation in this program to its other Child Survival/Primary Health Care programs/activities in developing countries; or, if child survival is a new technical area, the rationale for expanding into this new area;

♦Briefly describe:
a)the organization's experience in implementing, monitoring, and evaluating community-level primary health care/child survival programs;
b)the organization's experience and methodology for backstopping and transferring to their partners, technical and managerial skills;

♦In view of the preceding statements regarding the organization, describe the challenges faced by your organization with respect to this proposed program that will require particular attention, and describe how you intend to monitor and address these challenges.

♦Describe and document the organization's operations in the country proposed, and current agreements and working relationships with the proposed host country government and other organizations;

♦Provide an organizational chart that clearly delineates the key personnel responsible for technically backstopping this project in the PVO's US headquarters office and in-country office, how they fit into the overall organization, and the linkages between headquarters, regional office (if applicable), and/or field program personnel.

♦Provide information on the U.S. based key personnel including:
a)resumes, or position descriptions if personnel are not yet hired;
b)the percentage of time to be devoted to this project;
c)percentage of time proposed for other USAID-funded child survival and/or health grants programs for which they are responsible;

♦If the PVO is submitting more than one application, discuss how the activities in this application relate to the other applications;

♦For Mentoring Partnerships, provide, in an annex, a draft Agreement between the two organizations applying for this grant category, which they must sign before an award is made. Include the defined roles, responsibilities and accountability of each partner organization.

♦List separately, in an annex:

a)all federal- and non-federal-funded contracts, grants or cooperative agreements involving similar or related programs in the country proposed, for the last three years. Include: (1) name of the organization or agency funding the programs, (2) contact person at the organization, (3) total program budget, areas where activities were or are being implemented, (4) start and end dates, and (5) main program activities.
b)all other applications pending for federal- or non-federal funding for similar or related programs in the proposed country;

♦Please note the requirement to submit the Self Certification Package, Section A. of this RFA.

E.5.Proposed Program Description

a.Site Selection and Analytical Basis for Proposed Program (1-2 pages)

♦Briefly describe the location of the proposed program (a map with scale is appreciated), the estimated total population and number of children under five years of age living in the program site (and identify the sources for the data on the site's population), and socioeconomic characteristics of the population (such as economy, religion, status of women, ethnic groups, literacy, etc.).

♦Briefly describe the levels and major causes of under-five mortality in the country, and (if available) in the proposed program area, and (if maternal mortality is to be addressed by the proposed program) estimated levels and causes of maternal mortality. (Include the sources of all mortality data.)

♦Briefly describe the existing health and child survival related programs, facilities, and activities in the program area (including those of your PVO, the MOH, NGOs, and private and traditional health providers). Discuss the strengths and weaknesses of current services, and opportunities for local collaboration and support between your proposed program and these other organizations and services.

♦Describe the process you used for selecting the site and designing the child survival program, including organizations consulted in-country. Discuss the reasons for selecting the country and site, and provide a thorough justification of your choice of interventions and strategies. Avoid discussing the global importance of Child Survival interventions. Address the site. If your PVO has implemented primary health programs in this country, discuss this experience and describe how the proposed program builds on your in-country experience.

♦Applicants applying for funding for a 3rd cycle need to explain why the country, the site, and the program are a high priority for continuing assistance under this program. The PVO must indicate how the nature of the program has changed, changes in the intervention strategy, other donor activities,and the capability of local organizations.

♦Describe how the proposed program is consistent with the USAID Mission's strategic objectives (for the country in which the program is proposed). Describe the policies of the national government that relate to child survival, and how the proposed program is consistent with these policies.

b.Program Design

♦State the proposed program's goal(s), list all proposed program interventions, and estimate the percentage of overall program effort to be devoted to each intervention.

♦Describe your overall program design, including the main strategies and activities, and current and planned collaboration with local organizations.

♦Discuss the relationship this program will have with other health-related activities in the project area (including those of this and other PVOs, NGOs, private and traditional providers, and government), and discuss the role the project will have in relation to the area's health facilities.

♦Describe any new methods, strategies, or materials to be developed or used by the proposed program, which may be applicable on a wider scale or beneficial in other areas or programs.

c.Child Survival Interventions

For each intervention:(refer to C.2 for the list of interventions supported under the CSGP)

♦State the objectives and results, in measurable terms, that the organization hopes to achieve over the life of the program, and the target groups for the proposed intervention.

♦Describe, and provide a rationale for, the proposed strategy and methods that will be used to implement the intervention. Briefly describe how the program will address the essential elements of the intervention (such as quality, access, behavior change and education of community members, essential household actions, etc.). Briefly describe the specific activities to be implemented, who will implement these activities, and how the program will integrate the activities with, or will effectively support, existing health related services in the area.

♦Provide an explanation of, and justification for, any proposed

intervention activities or strategies that differ from MOH policy.

d.Management Plan (2-3 pages)

♦Describe the proposed management structure for project supervision and financial management. At a minimum, include the roles of the headquarters vis a vis the field.

♦Identify and briefly describe the qualifications (training and experience) for the key field staff positions to be funded through the proposed program, list the main responsibilities, and estimate the number of person-months programmed for each position. Briefly describe the experience of proposed PVO country and program site staff with each child survival intervention, and plans for upgrading their skills.

♦For each kind of field staff with whom the proposed project will work (including MOH and NGO health workers, their supervisors, and all other personnel to be involved in the delivery of program-related child survival services): Identify the type of health worker (e.g., nurse, community health worker, traditional birth attendant), identify their current organizational affiliation (or note that these staff are to be recruited in the future), identify whether they are paid or volunteers, estimate the number of this type of worker to be involved in the program, list their main duties related to the supervision and provision of child survival services, and estimate their time devoted to the proposed child survival activities.

♦Describe any committees or community groups with which the proposed program will work, their role in the child survival program, and the number of each type of group. Discuss how the program will work with these groups, including the frequency and nature of interaction, and identify which staff will work with the groups.

♦Briefly explain the rationale for working with these types and numbers of health facilities, workers, and committees. Briefly describe how these entities will relate to and support each other.

♦Describe your tentative plans for training each type of health worker to deliver child survival services. Describe how you will decide the topics, content, methods, and duration of training.

♦If volunteers will be involved in the delivery of child survival services, explain how they will sustain their participation.

e.Work Plan (2-3 pages)

♦Propose a brief, but illustrative work plan for the life of the program. If you plan to phase in interventions or sites, include a

schedule. Include a more detailed action plan (calendar of key activities) for the first year of the program. DO NOT SUBMIT A DIP.

f.Performance Monitoring and Evaluation (1-2 pages)

♦Discuss your plans for conducting assessments, studies, or surveys in the program site if this proposed program is funded. Include your plans for learning more about the coverage, quality, and needs of existing health services, and about the beliefs, practices, and vocabulary of the local population. Describe how this information will be used to revise the program's objectives and plans.

♦Describe the strategies, methods, and tools that will be used to monitor and improve the performance of health workers and the quality and coverage of intervention activities (including those carried out in cooperation with other organizations).

E.6.Partnerships and Capacity Building (1-2 pages)

♦Describe planned partnerships with non-governmental and local governmental organizations, including the reason for the relationship, involvement of partners in design of the proposed project, activities to be carried out, the local partners contribution to the partnership and how the partnership will be evaluated. Identify any other organizations that are already working in the site with the program's proposed partners. Attach letters of support from cooperating governmental and other organizations in an annex.

♦Describe the current capacity, including financial, human, and material resources, of local partners, and how the program plans to increase the managerial and technical skills of staff in those local institutions that are to sustain program activities. What evidence is there that these local organizations will sustain program activities?

E.7.Sustainability (2-3 pages)

♦Define what "sustainability" will mean for your proposed program from the perspective of your PVO. Describe what the program hopes to leave in place at the end of this child survival grant. What continued financial or other support from communities, the MOH, NGOs, other local organizations, or other donors, will be required to sustain program-related activities or benefits after the end of USAID/BHR/PVC funding? What are your plans for getting these organizations and groups involved in planning for sustainability?

♦Describe what local technical resources will be developed to replace or expand existing ones.

♦Describe how community resources and priorities will contribute to the program's long-term sustainability.

♦Discuss the cost-effectiveness of the program, and the extent to which the proposed partnerships(s) achieve cost savings or economies of scale. Define the beneficiary population for the proposed program, estimate the number of beneficiaries the program will serve, and calculate the cost per beneficiary.

♦Briefly describe how the program will address financial sustainability, including, if applicable: (a) financial commitments by other organizations; (b) a strategy for obtaining private sector support; or (c) cost-recovery methods to be explored.

♦Applicants applying for funding for a 3rd cycle need to describe the PVO's devolution strategy including a detailed plan for transitioning to other funding or transferring all activities to the local partner. Describe how the benefits of the program might be scaled up to a broader population, either by the PVO or other actors.

E.8.Past Performance

♦Discuss the PVOs adherence to the terms and conditions of its current or past contracts, cooperative agreement or grants, including the technical and administrative aspects of performance.

♦If your PVO has been funded in the past in this country through the PVO CSGP, include the summary and recommendations sections of all previous PVO CS Grants Program evaluations and the entire most recent evaluation in an annex of this application, and provide a thorough discussion here of how your program has addressed each recommendation of the most recent evaluation (if conducted within the last three years).

E.9.BHR/PVC Strategic Plan

♦Explain how the proposed activity contributes to the achievement of each of BHR/PVC's intermediate results described in the PVC Strategic Plan;

♦Describe how the PVO conveys program results for raising public awareness of the PVO's work in developing countries.
ANNEX A
RFA 938-98-A-0500-14Standard Form 424
OMB Approval No. 0348-0043
APPLICATION FOR
FEDERAL ASSISTANCE2. DATE SUBMITTEDApplicant IdentifierNA1.TYPE OF SUBMISSION:3. DATE RECEIVED BY STATEState Application IdentifierApplicationPreaplication NANANA Construction Construction4. DATE RECVED BY FEDERAL AGENCYFederal Identifier X Non-Construction Non-ConstructionNA5. APPLICATION INFORMATIONLegal Name:Organizational

UnitAddress (give only county, state, and zip code):Name and telephone number of person to be contacted on matters involving this application (give area code)6. EMPLOYER IDENTIFICATION NUMBER (EIN):7. TYPE OF APPLICATION: (enter appropriate letter in box)MA. StateH. Independent School Dist8. TYPE OF APPLICATIONB. CountyI. State Controlled Instiurion of Higher Learning X New Continuation Revision C. MunicipalJ. Indian TribeIf Revision, enter appropriate letter(s) in box(es)D. TownshipK. IndividualA. Increase AwardD. Decrease DurationE. InterstateL. Profit OrganizaitionB. Decrease AwardE. Other (specify):
F. IntermunicipalM. Other (specify)C. Increase DurationG. Special Dist.10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:9. NAME OF FEDERAL AGENCY
NAUSAID/BHR/PVC TITLE:11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:12. AREAS AFFECTED (Cities, Counties, States, etc.):13. PROPOSED PROJECT14. CONGRESSIONAL DISTRICTS OF:START DATEEND DATEa. Applicantb. ProjectNANA15. ESTIMATED FUNDING:16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?a. Federal$b. Applicant$a.YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS REVIEW ON:c. State$ NAd. Local$ NADATE e. Other$B.NO.
X PROGRAM IS NOT COVERED BY E.O. 12372
X OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEWf. Program Income$g. TOTAL$17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT? Yes If "Yes", attach an explanation
No18.TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRU AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.a. Type Name of Authorized Representativeb. Titlec. Telephone Numberd. Signature of Authorized Representativee. Date Signed
Previous Edition usableStandard Form 424 (REV 4-92)
Authorized for Local RepresentativePrescribed by OMB Circular A-102ANNEX A
RFA 938-98-A-0500-14

INSTRUCTIONS FOR THE SF 424

Public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget. Paperwork Reduction Project (0348-0043), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET, SEND IT TO THE ADDRESS PROVIDED BY THE

SPONSORING AGENCY.

This is a standard form used by applicants as a required facesheet for preapplications and applications submitted for Federal assistance. It will be used by Federal agencies to obtain applicant certification that States which have established a review and comment procedure in response to Executive Order 12372 and have selected the program to be included in their process, have been given an opportunity to review the applicant's submission.

Item:Entry:

1.Self-explanatory.

2.Date application submitted to Federal agency (or State if applicable) & applicant's control number (if applicable).

3.State use only (if applicable).

4.If this application is to continue or revise an existing award, enter present Federal identifier number. If for a new project, leave blank.

5.Legal name of applicant, name of primary organizational unit which will undertake the assistance activity, complete address of the applicant, and the name and telephone number of the person to contact on matters related to this application.

6.Enter Employer Identification Number (EIN) as assigned by the Internal Revenue Service.

7.Enter the appropriate letter in the space provided.

8.Check appropriate box and enter appropriate letter(s) in the space(s) provided:

- "New" means a new assistance award.

- "Continuation" means an extension for an additional funding/budget period for a project with a projected completion date.

- "Revision" means any change in the Federal Government's financial obligation or contingent liability from an existing obligation.

Item:Entry:
9.Name of Federal agency from which assistance is being requested with this application.

10.Use the Catalog of Federal Domestic Assistance number and title of the program under which assistance is requested.

11.Enter a brief descriptive title of the project. If more than one program is involved, you should append an explanation on a separate sheet. If appropriate (e.g., construction or real property projects), attach a map showing project location. For preapplications, use a separate sheet to provide a summary description of this project.

12.List only the largest political entities affected (e.g., State, counties, cities).

13.Self-explanatory.

14.List the applicant's Congressional District and any District(s) affected by the program or project.

15.Amount requested or to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions should be included on appropriate lines as applicable. If the action will result in a dollar change to an existing award, indicate only the amount of the change. For decreases, enclose the amounts in parentheses. If both basic and supplemental amounts are included, show breakdown on an attached sheet. For multiple program funding, use totals and show breakdown using same categories as item 15.

SF 424 Back (Rev. 4-92)
INSTRUCTIONS FOR THE SF 424 (continued)

16.Applications should contact the State Single Point of Contact (SPOC) for Federal Executive Order 12372 to determine whether the application is subject to the State intergovernment review process.

17.This question applies to the applicant organization, not the person who signs as the authorized representative. Categories of debt include delinquent audit disallowances loans and taxes.

18.To be signed by the authorized representative of the applicant. A copy of the governing body's authorization for you to sign this application as official representative must be on file in the applicant's office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)

ANNEX A
RFA 938-98-A-0500-14Standard Form 424A
Budget Information - Non-Construction Programs

SECTION A - BUDGET SUMMARYGrant Program
Function
or Activity
{a}Catalog of Fderal
Domestic Assistance Number
{b}Estimated Unobligated FundsNew or Revised BudgetFederal
{c}Non-Federal
{d}Federal
{e}Non-Federal
{f}Total
{g}1. HeadquartersNANA$NA$$$2. FieldNANANA3. NANANANANANANA4. NANANANANANANA5.TOTALSNANA$NA$$$SECTION B - BUDGET CATEGORIES6.Object Class CategoriesGrant Program, Function or ActivityTotal
{5}{1}{2}{3}{4} a. Personnel (1)$$$NANAb. Fringe Benefits (1)NANAc. Travel (1)NANAd. Equipment (3)NANAe. Supplies (3)NANAf. Contractual (3)NANAg. Construction N/ANANAh. Other (1), (2) (see notes)NANAi. Total Direct Charges (sum of 6a-6h)NANAj. Indirect Charges (4)NANAk. TOTALS (sum of 6i and 6j) $$$$$7. Program Income$$$$$

STANDARD FORM 424A (cont'd)

SECTION C - NON-FEDERAL RESOURCES(a) Grant Program(b) Applicant(c) State(d) Other Sources(e) TOTALS8. Headquarters$$NA$$9. FieldNA10. NANANANA11. NANANANA12. TOTAL (sum of lines 8-11)$$NA$$SECTION D - FORECASTED CASH NEEDS13. FederalTotal for 1st Year1st Quarter2nd Quarter3rd Quarter4th quarter$$$$$14. Non-Federal15. TOTAL (sum of lines 13 and 14)SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT(a) Grant ProgramFuture Funding Periods(b) First(c) Second(d) Third(e) Fourth16. Headquarters$$$$17. Field18. NANANANANA19. NANANANANA20. TOTAL (sum of lines 16-19)$$$$SECTION F - OTHER BUDGET INFORMATION21. Direct Charges:22. Indirect Charges:23. Remarks:
Authorized for Local ReproductionStandard Form 424 A (Rev. 4-92)
Page 2ANNEX A
RFA 938-98-A-0500-14
Standard Form 424A (cont'd.)INSTRUCTIONS FOR THE SF 424A

Public reporting burden for this collection of information is

estimated to average 180 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget. Paperwork Reduction Project (0348-0044), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET, SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

General Instructions

This form is designed so that application can be made for funds from one or more grant programs. In preparing the budget, adhere to any existing Federal grantor agency guidelines which prescribe how and whether budgeted amounts should be separately show for different functions or activities within the program. For some programs, grantor agencies may require budgets to be separately shown by function or activity. For other programs, grantor agencies may require a breakdown by function or activity. Sections A, B, C and D should include budget estimates for the whole project except when applying for assistance which requires Federal authorization in annual or other funding period increments. In the latter case, Section A, B, C and D should provide the budget for the first budget period (usually a year) and Section E should present the need for Federal assistance in the subsequent budget periods. All applications should contain a breakdown by the object class categories shown in Lines a-k of Section B.

Section A. Budget Summary Lines 1-4 Columns (a) and (b)

For applications pertaining to a single Federal grant program (Federal Domestic Assistance Catalog number) and not requiring a functional or activity breakdown, enter on Line 1 under Column (a) the catalog program title and the catalog number in Column (b).

For applications pertaining to a single program requiring budget amounts by multiple functions or activities, enter the name of each activity or function on each line in Column (a), and enter the catalog number in Column (b). For applications pertaining to multiple programs where none of the programs require a breakdown by function or activity, enter the catalog program title on each line in Column (a) and the respective catalog number on each line in Column (b).

For applications pertaining to multiple programs where one or more programs require a breakdown by function or activity, prepare a separate sheet for each program requiring

the breakdown. Additional sheets should be used when one form does not provide adequate space for all breakdown of data required. However, when more than one sheet is used, the first page should provide the summary totals by programs.

Lines 1-4, Columns (c) through (g)

For new applications, leave Columns (c) and (d) blank. For each line entry in Columns (a) and (b), enter in Columns (e), (f), and (g) the appropriate amounts of funds needed to support the project for the first funding period (usually a year).

For continuing grant program applications, submit these forms before the end of each funding period as required by the grantor agency. Enter in Column (c) and (d) the estimated amounts of funds which will remain unobligated at the end of the grant funding period only if the Federal grantor agency instructions provide for this. Otherwise, leave these columns blank. Enter in columns (e) and (f) the amounts of funds needed for the upcoming period. The amount(s) in Column (g) should be the sum of amounts in Columns (e) and (f).

For supplemental grants and changes to existing grants, do not use Columns (c) and (d). Enter in Column (e) the amount of the increase or decrease of Federal funds and enter in Column (f) the amount of the increase of non-Federal funds. In Column (g) enter the new total budgeted amount (Federal and non-Federal) which includes the total previous authorized budgeted amounts plus or minus, as appropriate, the amounts shown in Columns (e) and (f). The amounts(s) in Column (g) should not equal the sum of amounts in Columns (e) and (f).

Line 5 - Show the totals for all columns used.

INSTRUCTIONS FOR THE SF 424A (continued)

Section B. Budget Categories

In the column headings (1) through (4), enter the titles of the same programs, functions, and activities shown on Lines 1-4, Column (a), Section A. When additional sheets are prepared for Section A, provide similar column headings on each sheet. For each program, function or activity, fill in the total requirements for funds (both Federal and non-Federal) by object class categories.

Lines 6a-i - Show the totals of Lines 6a to 6h in each column.

Line 6j - Show the amount of indirect cost.

Line 6k - Enter the total of amounts on Lines 6i and 6j. For all applications for new grants and continuation grants the total amount in column (5), Line 6k, should be the same as the total amount shown in Section A, Column (g), Line 5. For supplemental grants and changes to grants, the total amount of the increase or decrease as shown in Columns (1)-(4), Line 6k should be the same as the sum of the amounts in Section A, Columns (e) and (f) on Line 5.

Line 7 - Enter the estimated amount of income, if any, expected to be generated from this project. Do not add or subtract this amount from the total project amount. Show under the program narrative statement the nature and source of income. The estimated amount of program income may be considered by the federal grantor agency in determining the total amount of the grant.

Section C. Non-Federal Resources

Lines 8-11 - Enter amounts of non-Federal resources that will be used on the grant. If in-kind contributions are included, provide a brief explanation on a separate sheet.

Column (a) - Enter the program titles identical to Column (a), Section A. A breakdown by function or activity is not necessary.

Column (b) - Enter the contribution to be made by the applicant.

Column (c) - Enter the amount of the State's cash and in-kind contribution if the applicant is not a State or State agency. Applicants which are a State or State agencies should leave this column blank.

Column (d) - Enter the amount of cash and in-kind contributions to be made from all other sources.

Column (e) - Enter totals of Columns (b), (c), and (d).

Line 12 - Enter the total for each of Columns (b)-(e). The amount in Column (e) should be equal to the amount on Line 5, Column (f) Section A.

Section D. Forecasted Cash Needs

Line 13 - Enter the amount of cash needed by quarter from the grantor agency during the first year.

Line 14 - Enter the amount of cash from all other sources needed by quarter during the first year.

Line 15 - Enter the totals of amounts on Lines 13 and 14.

Section E. Budget Estimates of Federal Funds Needed for Balance of the Project

Lines 16-19 - Enter in Column (a) the same grant program titles shown in Column (a), Section A. A breakdown by function or activity is not necessary. For new applications and continuation grant applications, enter in the proper columns amounts of Federal funds which will be needed to complete the program or project over the succeeding funding periods (usually in years). This section need not be completed for revisions (amendments, changes, or supplements) to funds for the current year of existing grants.

If more than four lines are needed to list the program titles, submit additional schedules as necessary.

Line 20 - Enter the total for each of the Columns (b)-(e). When additional schedules are prepared for this Section, annotate accordingly and show the overall totals on this line.

Section F. Other Budget Information

Line 21 - Use this space to explain amounts for individual direct object-class cost categories that may appear to be out of the ordinary or to explain the details as required by Federal grantor agency.

Line 22 - Enter the type of indirect rate (provisional, predetermined, final or fixed) that will be in effect during the funding period, the estimated amount of the base to which the rate is applied, and the total indirect expense.

Line 23 - Provide any other explanations or comments deemed necessary.

ANNEX B RFA 938-98-A-0500-14
PVO CHILD SURVIVAL
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(In Alphabetical Order by Country)

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BHR/PVC/CSH:WS:8/29/97

ANNEX C-1
RFA 938-98-A-0500-14PVO CHILD SURVIVAL

United States Agency for International Development
Bureau for Humanitarian Response
Office of Private and Voluntary Cooperation
PVO Child Survival Grants Program

Technical Reference Materials and Guidance for Preparation of Detailed Implementation Plans By Intervention

September 4, 1997

These draft intervention-specific guidelines, along with the recommended reference materials, define and describe the state of the art for each intervention, according to the specialists consulted by BHR/PVC. The draft guidelines are enclosed to help PVOs plan high quality child survival programs. Detailed Implementation Plans (DIPs) should be submitted to BHR/PVC within six months of the program start date (except for Entry Grants), following guidance to be provided in the future. Please do not submit a DIP with a grant application.

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-Maternal and Newborn Care 39
-Child Spacing 47
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BHR/PVC would appreciate feedback regarding the references cited in these guidelines. Which of these are most helpful, and which are

less appropriate? Which reference materials should be added? Other suggestions regarding the contents of these guidelines would also be welcome. (Please respond to Eric Starbuck. Phone: 703-351-0229, Fax: 351-0212 or -0228, Internet e-mail estarbuck@usaid.gov)References that specifically apply to an intervention are listed after each intervention description. The following references are relevant to several interventions:

1. Pneumonia Care Assessment Methods Toolbox. Draft, 1996. The Johns Hopkins University PVO Child Survival Support Program. Tools designed for PVO CS programs to assess the quality of pneumonia case management services, access to PCM, and local pneumonia related beliefs, practices, and vocabulary. The qualitative/ethnographic approaches, and the health facility/worker assessment methods used in this pneumonia-specific package are very relevant for collecting information concerning other child survival interventions. These materials were largely adapted from, but are much more appropriate for use at the program site level than, the WHO ARI Programme Health Facility Survey and Focussed Ethnographic Survey.

2. Survey Trainer's Guide for PVO Child Survival Program Rapid Knowledge, Practice, and Coverage (KPC) Surveys. January 1997, The Johns Hopkins University PVO Child Survival Support Program. The standardized KPC survey may be used by CS programs to collect baseline information, help programs focus on priority health needs of populations, help set measurable objectives, and to help measure achievement of objectives. The Guide is designed for use by those who participate in the Training of Survey Trainers (TOST) workshop

3. Murray, John, Gabriella Newes Adeyi, Judith Graeff, Rebecca Fields, Mark Rasmuson, Rene Salgado, Tina Sanghvi. 1997. Emphasis Behaviors in Maternal and Child Health: Focussing on Caretaker Behaviors to Develop Maternal and Child Health Programs in Communities. Published for USAID by the BASICS Project. Includes a list and discussion of sixteen emphasis behaviors (developed by a multi-disciplinary team of medical and behavioral specialists) that, if practiced by caretakers, could improve maternal and child health in developing countries. Also includes a discussion of the criteria used for identifying the sixteen behaviors, and the technical justification for each of the emphasis behaviors. Methods to help project managers select which of the sixteen behaviors to focus on in their projects, develop strategies to target the emphasis behaviors, and monitor and evaluate behavior change, are also reviewed. (14 pages plus annexes) Available from: Information Center, BASICS Project, 1600 Wilson Blvd., Suite 300, Arlington, VA 22209. Phone: (703) 312-6800, Fax: 312-6900. (This document was provided to the participants of the May 1997 BASICS PVO/IMCI workshop held in Silver Spring, Maryland.)4. Powers MB. Sustainability Findings of 12 Expanded PVO Child Survival Projects. PVO Child Survival Support Program, June 1995 (available from USAID/BHR/PVC/CSH or from JHU/PVO CSSP).

5. USAID strategies can be retrieved from the INTERNET. The

INTERNET address of the Agency Gopher is: gopher.info.usaid.gov.
(a)"Stabilizing World Population Growth and Protecting Human Health: USAID's Strategy" can be found under "Stabilizing Population Growth/Protecting Health" in the USAID Gopher Root Menu.
(b)Specific strategic objectives of each USAID Mission can be found under "Regional/Country Focus" in the USAID Gopher Root Menu. Within the "Regional/Country Focus," each country with a USAID Mission is listed. The "FY 1996 Congressional Presentation" within the country listing contains strategic objectives of each USAID Mission.

6. The Progress of Nations (published by UNICEF annually).

7. The State of the World's Children (published by UNICEF annually).

8. A toolbox for building health communication capacity. HealthCom, Communication for Child Survival Project, 1995. Available from: Information Center, BASICS Project, 1600 Wilson Blvd., Suite 300, Arlington, VA 22209. Phone: (703) 312-6800, Fax: 312-6900.IMCI focusses on health facility-based out-patient case management of sick children between the ages of one week and five years for five conditions associated with about 70% of under five deaths: pneumonia, diarrhea, malaria, measles, and malnutrition. "The IMCI course is aimed at literate first-level facility health workers who can comfortably read and understand textual learning materials." The 1995 field test of the materials in Tanzania "demonstrated the effectiveness of the course for in-service training of doctors, medical assistants, and clinical nurses." The current IMCI materials, training course, and algorithm for assessing and treating children are not appropriate for marginally literate health workers. Materials for a complementary IMCI course, based on the same algorithm, but designed for less literate health facility clinicians, are under development. Simplified IMCI algorithms and training materials for community health workers may be developed in the future.
Wall charts and training modules are available for adaptation to individual country needs and for use under carefully monitored conditions. The materials require adaptation for use in all countries, an extensive effort which may take four to six months. The following six countries are participating in early use of the IMCI course with intensive WHO collaboration (as of November 1996): Indonesia, Nepal, Philippines, Uganda, Tanzania, and Peru. Brazil, Bolivia, the Dominican Republic, Ecuador, Haiti, Botswana, Ethiopia, Madagascar, Mali, Morocco, Niger, Togo, Zambia, India, and Viet Nam are also preparing for the introduction of IMCI training. PVOs working in these countries are encouraged to keep in touch with the MOH, WHO, UNICEF, and/or BASICS concerning IMCI if their programs are related to the management of childhood illness at health facilities.
BHR/PVC suggests that PVO programs implement, or support the implementation of, a carefully selected package of complementary child survival interventions in an integrated way. However, BHR/PVC will only support PVO involvement in IMCI when this is part

of a national effort to introduce IMCI. In areas where IMCI has not yet been introduced, health workers may still be trained to effectively manage sick children using the intervention-specific protocols and training materials recommended by the MOH, or those referenced in these guidelines. CHWs should be trained using intervention-specific algorithms and training materials designed for community health workers. The WHO ARI materials for CHWs (cited in the PCM section of these guidelines), that address the overlap in the presentation and treatment of pneumonia and malaria, are a good example of appropriate materials for CHWs.
PVOs implementing case management interventions for malnutrition, diarrhea, pneumonia, or malaria, are encouraged to review the IMCI materials for up-to-date information concerning these interventions, but describe their plans in their DIP by addressing the issues in the nutrition, diarrhea, pneumonia and/or malaria sections of these guidelines.
More information on IMCI may be found on the website of the WHO Division of Child Health and Development (http://cdrwww.who.ch).The goal of this intervention is to work toward achieving full immunization coverage in the program area for all infants by the end of their first year of life, and tetanus toxoid immunization for women of child bearing age (15 - 49 years). PVOs are encouraged to support polio eradication activities in their program sites.

Programs implementing this intervention should address all of the following issues in their DIP, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

1. Incidence and Outbreaks
If the MOH is carrying out surveillance of vaccine preventable diseases, give the most recent surveillance data available for the program area. Describe any outbreaks of vaccine preventable diseases that occurred within the last two years in or near to the program area.

2. Baseline Coverage Estimates
Using the results of the baseline survey, give the most up-to-date coverage estimates in your service area for DPT1, OPV3, and measles, in children age 12-23 months. Estimate the current dropout rate for DPT immunizations [(DPT1 - DPT3) ÷ DPT1]. Estimate the percent of children 12-23 months who are completely immunized. Describe the tetanus toxoid (TT) immunization status of women of childbearing age or the percentage of births protected by TT. Compare your data with the most recent data available for the district, or with national coverage levels.

3. MOH Policies
Describe the MOH immunization strategy. Does it include routine services, means for making up missed immunizations, mass campaigns, etc. Include the MOH immunization schedule for your country or

program area. Include details on any MOH immunization policies that differ from WHO/UNICEF guidelines and on why they differ.

4. Knowledge & Practice

Using the results of the baseline survey and other available sources, describe the knowledge and practices of mothers regarding immunization.

5. Approach

Describe the existing barriers to achieving full immunization coverage in the program area, and discuss the overall quality of existing immunization services. Describe your planned immunization component for children and for women of childbearing age; include PVO and MOH roles in education, community mobilization, vaccine administration, and in monitoring and improving the quality of immunization services. How will the program coordinate its activities with those of the Ministry of Health? Can program beneficiaries obtain immunizations all year, or only during campaigns? Are immunizations given from fixed or mobile facilities? How does the program plan to reach "high risk" populations? How will the supply of vaccines be ensured? How will staff protect themselves from exposure to blood-borne infections?

6. Individual Documentation

Attach the MOH/EPI immunization card. Indicate whether this is the card the program will use. How reliable is the card supply? Identify documentation to be used in the case where a child's card is lost. Specify how immunizations will be recorded during mass campaigns. Identify any expected expenditures for cards, forms, etc. State on what document womens' TT vaccination will be recorded (on antenatal cards, or a separate card?). Indicate where the card will be kept. If both these cards will be kept by the mothers, how will retention of cards by mothers be promoted?

7. Drop-outs - Children

In terms of childhood immunization coverage, describe the major causes of, and strategies for reducing, the number of dropouts and missed opportunities in your program area.

8. Drop-outs - Women

In terms of tetanus toxoid coverage of women, describe the major causes of, and strategies for reducing, the number of dropouts and missed opportunities in your program area, and the strategy for increasing demand for tetanus toxoid immunizations.

9. Population

State the number, by age, of the beneficiary population for immunizations. Give the estimated number of newborns each year, calculate the number of visits required to reach full coverage for children by 12 months of age. Which women will the program target for TT, women of child bearing age or pregnant women? Give the estimated number of women the program will target for TT.

10. Cold Chain Support

Identify existing weak links in the cold chain and the source of

this assessment. What does the program intend to do in cold chain maintenance and monitoring? Attach the program protocol for monitoring vaccine temperature. Identify equipment you have purchased (or will purchase) to monitor and maintain the cold chain. Report any recent estimates, if available from WHO, UNICEF, or other sources, of vaccine efficacy at the district level.11 Surveillance
If you plan to have EPI disease surveillance activities, identify the vaccine preventable diseases that will be under surveillance, and for each, give the case definitions that will be used. Will surveillance be carried out in health facilities and/or in the community? Who will carry out surveillance in each setting? How will that person(s) be trained? Describe the process for identifying, reporting, and following-up suspected cases. What will be the role of the PVO and MOH in responding to disease outbreaks?

12. Community Support/Sustainability
Describe evidence of, or plans for, community support for immunization services, such as in kind or cash contributions, cost recovery, local leader involvement, etc.

13. Other issues
In this section, please address each of the issues listed in section D.4 of the DIP Guidelines which you have not already discussed above (points a through h, including staff experience, training and supervision, differences from MOH policies, and the references you used).

Highly Recommended Reference Materials1. EPI Essentials: A Guide for Program Officers. John Snow, Inc. Second Edition, August 1989. Available from: Information Center, BASICS Project, 1600 Wilson Blvd., Suite 300, Arlington, VA 22209. Phone: (703) 312-6800, Fax: (703) 312-6900.
2. Training for Mid-Level Managers (MLM). Published by WHO, 1991. (WHO/EPI/MLM/91.2)

Other Recommended Reference Materials
3. Immunization in Practice: A Guide for Health Workers Who Give Vaccines. WHO. Published by Oxford University Press, New York.The goal of this intervention is to decrease malnutrition-associated under-five deaths by improving the nutritional status of infants, children, and/or pregnant and lactating women.
Breastfeeding promotion is related to several child survival interventions, and has therefore been described in a separate section of these guidelines. PVOs planning to implement a breastfeeding intervention should thus provide a detailed description of breastfeeding activities in the breastfeeding section of their DIP.
Interventions to prevent child malnutrition, rehabilitate severely malnourished children, and promote maternal nutrition, including micronutrient interventions, are discussed below. PVOs need not attempt all of the nutrition components described here. Selected components, however, should be sufficiently complete to reasonably

expect to achieve impact.

Programs implementing this intervention should address all of the following issues in their DIP, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

Nutritional Improvement for Infants and Children
Research now documents that even mild or moderate malnutrition significantly contributes to mortality in young children. Interventions to prevent childhood malnutrition should promote feeding practices which ensure adequate growth and reduce the detrimental effects of illness. PVOs are encouraged to emphasize optimal feeding practices which differ by the age of the infant/child, and by whether the child is ill or well. Optimal feeding practices include the promotion of breastfeeding (discussed in a separate section); the timely introduction of appropriate complementary foods, in addition to breastmilk; small, frequent feeds; increasing energy density of foods by adding oil, fat, or sugar; and continued feeding and catch up feeding during and after illness.
Identification and referral of severely malnourished children can be another element of a nutrition intervention. PVOs should describe any plans for providing rehabilitation services.

1. Nutrition Status
Provide the most up-to-date estimates for the number and percentage of malnourished children in the region or service area. (Cite source and year of data). Indicate whether estimates are based on weight-for-height, weight-for-age, or height-for-age measurements, and give the standards used. Discuss issues of seasonality of malnutrition, and any age, gender, or ethnic differences noted. Describe food availability and food security in the program area (cite source). Include any additional appropriate information which would contribute to understanding the existing nutrition situation.

2. Current Beliefs and Practices
Describe the usual weaning practices in the area, including the number of times children are fed each day, what is known about diet quality/composition [major nutrients and micronutrients], quantity, preparation, and ways children are fed (i.e., use of utensils, active supervision by an adult, alone on the floor, etc.). Differentiate by age, such as: 6-11 months, 12-17 months, 18-23 months, 24+ months. If mothers are typically absent from the home during the day, who are the primary caregivers?
Discuss cultural beliefs that apply to infant feeding practices and to the distribution of food within families. Include information about feeding children during and following illness.

3. MOH Policy and Nutrition Activities in Area
Describe national government policies or programs which affect the nutritional status of infants and children at the community level,

including supplemental feeding programs.

4. Program Approach
Discuss your strategy for improving children's nutritional status in the program area, including plans to address the causes of malnutrition identified above. Describe how the program will coordinate nutrition interventions with existing nutrition activities in the area and with other MCH activities (such as immunization, maternal care, or family planning).
What strategies will the program use to increase caloric intake in vulnerable children? What nutrition messages will the program deliver to improve the content and frequency of complementary feeding to small children during the weaning period? How will the program develop community support systems to reinforce behavior change?
Discuss how the program will monitor and improve the quality of intervention activities.

Growth Monitoring, Counseling, and Follow-up
Growth monitoring may be included in a nutrition intervention, to identify children who are falling behind in growth and take corrective action, as well as to reinforce positive feeding behaviors. Growth monitoring has long been a major component in PVO Child Survival nutrition programs. It is not, however, a nutrition intervention by itself. Provided essential program components are included, growth monitoring can be an important tool in both preventive and treatment programs. All growth monitoring activities require strong supervision and quality control in order to be effective. Growth monitoring programs should include the following: measuring the population at risk frequently; educating caregivers regarding the child's growth pattern; identifying faltering children promptly; determining the cause of growth faltering; and counseling caregivers of growth faltering children and providing for follow-up appropriate to the caregiver's situation and causes of the problem.
PVOs planning to do growth monitoring should provide appropriate training and retraining to ensure health workers have good clinical and interpersonal counselling skills. Strong supervision and quality control of nutrition counselling services is essential. As some children will fail to gain weight despite improved feeding practices, PVOs should address the issue of access to effective medical care and extra food for growth faltering children, including follow-up plans when the child returns to the community. The quality of the referral services should be noted in this section of the DIP. Growth monitoring programs should direct particular attention to those children least likely to be brought for weighing, by developing systems to identify and weigh them.

5. Approach to Growth Monitoring, Counseling, and Follow-up
If the MOH provides growth monitoring/promotion services, include national standards. Describe current growth monitoring activities in the program area. How will your strategy address the issues listed above? How frequently are young children weighed? What is the level of compliance in attendance and counselling? How will

your strategy overcome any constraints?
Describe the role of your program in weighing children, interpreting growth patterns, and providing nutrition counseling. Discuss how the program will train and supervise health workers, including quality assurance in service delivery. If the MOH weighs the children, what is the PVO's role and how is it coordinated with the MOH?
Which children in the program site are most likely to be malnourished? What age groups will the program focus on? How does the program plan to reach these children? Describe your criteria for determining growth faltering. Once a child is identified as growth faltering, what steps will the program take to improve that child's growth and prevent the child from faltering in the future? How will data collected from growth monitoring be used to monitor the effectiveness of the program's nutrition intervention? What mechanisms will be developed to provide feedback to staff and the community?
Attach a copy of the growth card the program will use, and state the documentation the program will use in the case of a lost card. How will the program promote retention of cards by mothers? Who provides these cards? How reliable is this supply?
Nutritional Improvement for Pregnant & Lactating Women
Improving the nutritional status of pregnant women improves birth weight, thus decreasing infant deaths, and protects the health of the mother. Preventive nutrition measures focusing on mothers should encourage consumption of appropriate foods in both caloric and nutrient content to promote maternal weight gain and prevent and treat micronutrient deficiencies. A woman should gain an average of 1 Kg per month during pregnancy. Increased energy requirements during pregnancy are actually modest (150 - 200 kcal/day) and can come from additional snacks or liquid sources such as juices or milk.
Lactating women have special nutritional requirements to provide adequate nutrition for their babies and avoid depletion of nutrient stores. A lactating woman needs to increase energy consumption to meet the demands of lactation in situations where she did not gain adequate weight during pregnancy, the birth weight of her baby was low, or she lacks confidence in her ability to breastfeed exclusively. A lactating woman and her baby will both benefit if the lactating woman receives a vitamin A supplement within the first 60 days after delivery.
Interventions designed to improve the nutritional status and delay pregnancy in non-pregnant adolescent girls may have a significant impact on infant and maternal nutritional status and mortality, but are beyond the scope of this program. PVOs may thus propose interventions in adolescent reproductive health, but fund these activities from sources other than BHR/PVC (such as PVO match funds.)

6. Nutrition Status
Describe the height/weight distribution at baseline for pregnant women in the program area, if available. What is known about the distribution of birth weights in the area? Does the program have any plans to collect additional data on maternal nutrition status?

7. Current Beliefs and Practices

Using the baseline survey results, estimate the percent of pregnant women who state they eat more, the same, or less than usual during pregnancy. What are the local beliefs with regard to food consumption and weight gain during pregnancy and lactation? Do mothers relate their own health status to their ability to breastfeed successfully? Do mothers or families take any precautions or change their work habits during pregnancy and lactation? From whom do mothers seek advice during pregnancy and lactation? Describe the most likely causes of maternal nutritional problems in the program area.

8. MOH Policy and Nutrition Activities in Area

Does the national government have specific policies or programs for maternal nutritional improvement?

Describe current nutrition or food policies, programs, and activities, including fortification and supplemental feeding programs, which effect the nutritional status of pregnant and lactating women in the program area.

9. Program Approach for Nutritional Improvement of Pregnant and Lactating Women

Explain how the program will address the issues identified above. Describe your strategy for identifying and enrolling pregnant and lactating women in nutrition programs. How will the program reach high risk groups? What messages will the program give to pregnant and/or lactating women? Discuss any qualitative assessments that your program has done, or will do, to develop appropriate nutritional messages and materials. What educational methods will the program use with mothers and influential family and community members? Who will the program train to provide these messages? How will the program monitor the effectiveness of these messages in behavior change? Describe the major constraints to improving maternal nutritional status in the program area and the program plans to overcome them.

Micronutrient Interventions

Micronutrient interventions are included as nutrition interventions, whether addressed via a food-based strategy, or with supplements. The major micronutrient deficiencies most appropriately addressed by PVOs include vitamin A, iron, and iodine. Each of the major micronutrients affecting child and maternal health require special implementation strategies in programming, and are described separately here.

Periodic supplements of vitamin A for children can prevent blindness and eye conditions due to vitamin A deficiency (xerophthalmia), as well as substantially reduce infectious disease-related mortality in deficient regions. Maternal supplementation with high dose vitamin A within two months after delivery assures adequate content in breastmilk. Immediate supplementation with high dose vitamin A capsules is particularly important for children with xerophthalmia, severe infectious disease (particularly measles, dysentery, and persistent diarrhea),

and severe protein-energy malnutrition. A long-term strategy may include education about locally appropriate sources of vitamin A. In areas where sources of vitamin A are scarce or expensive, PVOs may consider promoting home gardening or other horticultural activities (see section on Home Gardening). Nutrition education messages should promote consumption of oils and fats to enhance Vitamin A absorption.

Many PVO's find promoting consumption of iodine-fortified products such as salt, where available, practical for inclusion in their programs. In program areas where iodine deficiency is a problem, and where iodized salt is not available, programs may consider providing iodized oil supplements, if feasible. Programs can provide iodized oil supplements orally or by intramuscular injection. Other alternatives include iodization of water or administration of Lugol's iodine solution monthly.

In areas with significant malaria morbidity and intestinal parasitism, the causes of anemia may be multifactorial. Where anemia is due to dietary iron deficiency and significant dietary sources of iron are available, anemia prevention can take the form of nutrition education. Current research, however, questions the ability to meet all nutritional requirements for iron where animal dietary iron sources are limited. Inclusion of nutritional messages discouraging iron-inhibiting foods/fluids (such as tea with meals) and promoting iron-enhancing substances (such as Vitamin C rich foods) may contribute to the effectiveness of a dietary approach. Anemia in children may be treated with iron supplements, however, dosage recommendations for community based programs are still under development.

Programs considering an anemia intervention in areas where the prevalence of hookworm is greater than 20% among children aged two to five years, should also consider periodic deworming. Deworming is done for children aged two years or older. Treatment for children less than two years is not recommended as these children have much less exposure to infection.

Treatment of chronic malaria prevents and treats the resulting severe anemia. Some sources recommend iron supplements for treatment of malaria associated anemia in children. PVOs planning a malaria intervention may wish to consider providing iron supplements for children.

Iron deficiency in pregnant women is one cause of low birth weight, maternal morbidity, and mortality. Most local diets, especially those lacking animal sources of iron, do not contain sufficient absorbable iron to correct anemia during pregnancy. Iron/folate tablet distribution to pregnant women is thus encouraged.

Although micronutrient fortification is a long-accepted and successful means of protecting nutritional status in countries with suitable food distribution systems, this strategy is unlikely to be feasible for most PVO programs.

10. Program Approach to Micronutrients

Include estimates of the prevalence of xerophthalmia, anemia, and of goiter or cretinism, in children and in pregnant and lactating women, where available. Are there national standards for micronutrient supplements for children and for pregnant and

lactating women? Are micronutrient supplements included in the essential drug supplies?
Describe who will receive micronutrient supplements, when and under what conditions these will be given, and the specific purpose of the supplementation. Give details on supplement distribution, including the following: dose by age group (for both prevention and, if applicable, treatment); the source and reliability of the supplement supplies; and whether the program or MOH will distribute supplements when needed or through mass campaigns. If the program area has a high prevalence of anemia and hookworm, what steps will the program take to periodically deworm children?
Describe the program strategy for dietary approaches to micronutrient deficiencies. Address the same counselling and quality control issues raised in growth monitoring as they pertain to micronutrients.

Supplementary Foods
11. Program Approach to Supplementary Foods
If the program will provide supplementary foods (other than micronutrients), identify the source, and describe the activities planned. Who will be eligible for supplementary feeding? What are the criteria for entry into and exit from the supplementary feeding program? How often will the program give supplementary foods? Describe the nutritional value of the food, including micronutrient content, if known. Will providers counsel mothers? How will the program monitor supplementary feeding? How will the program ensure the food reaches the targeted beneficiaries? Will the supplementary food program be time limited? How will food supplements be phased-out?

Home Gardens
Home gardens have long been promoted as a nutrition activity by PVOs. The role gardens play in improving the diet of mothers and children is affected by many factors. PVOs wishing to pursue this strategy should address the questions below. Funding for this activity should come from sources other than BHR/PVC (such as PVO match).

12. Program Approach to Home Gardens
Describe the purpose of the home gardening activity (i.e. income generation, household nutritional improvement for women and children). Will the program emphasize production of calorie-dense or micronutrient-rich foods? If included as a nutrition strategy, describe the program's strategy to encourage household consumption of the garden products. Describe the educational techniques the program will use. Explain program inputs for gardening supplies and agricultural expertise. Include plans to monitor and evaluate this activity.

13. Other issues
In this section, please address each of the issues listed in section D.4 of the DIP Guidelines which you have not already discussed above (points a through h, including staff experience, training and supervision, differences from MOH policies, and the

references you used).

Recommended General Nutrition Reference Materials

1. Pinstrup-Andersen, P., Pelletier, D. Alderman, Eds. Child Growth and Nutrition in Developing Countries, Priorities for Action. Cornell University Press, 1995.
2. Baker, J., Martin, L., Piwoz, E. The Time to Act: Women's Nutrition and its Consequences for Child Survival and Reproductive Health in Africa, 1996. (Available in English and French from the SARA Project, c/o Academy for Educational Development (AED), 1255 23rd St. N.W., Washington, D.C. 20037)
3. Piwoz E. Ideal Nutrition Practices. Appendix E in the Report on the Fifth Annual Latin America Regional PVO Child Survival Workshop, Cerro Verde, El Salvador, 1995. (Available from PVO CSSP.)
4. Jelliffe DB, Jelliffe P. Growth Monitoring and Promotion in Young Children: Guidelines for the Selection of Methods and Training Techniques. Oxford University Press, 1990. ISBN 0-19-505623-X.
5. How to Weigh and Measure Children: Assessing the Nutritional Status of Young Children in Household Surveys. National Household Survey Capability Program. United Nations Department of Technical Co-operation for Development and Statistical Office, New York, 1986.
6. King FS, Burges A. Nutrition for Developing Countries. Second Edition, ELBS with Oxford Press, 1992. Order form available through: Dr. Felicity Savage, CDD Programme, World Health Organization, 1211 Geneva 27, Switzerland. Fax.: 41-22-791-4853.
7. Nabarro DN. Preconditions for Successful Growth Monitoring Programs in South Asia. PVO Child Survival Technical Report, Vol. 3, No. 2, PVO Child Survival Support Program, The Johns Hopkins University School of Hygiene and Public Health, November 1992.
8. Growth Monitoring and Promotion: Behavioral Issues in Child Survival Programs. Prepared for the Office of Health, USAID, by Ann Brownlee. Reference number PNABG 752. Available from USAID, Tel.: (703) 351-4006.

Recommended Reference Materials for Vitamin A

9. Sommer A. Vitamin A Deficiency and its Consequences: A Field Guide to Detection and Control. Third Edition. World Health Organization, Geneva, 1995.
10. Global Prevalence of Vitamin A Deficiency: Micronutrient Deficiency Information System Working Paper #2 WHO/NUT/95.3, WHO, 1995.
11. Vitamin A Supplements: A Guide to their Use in the Treatment and Prevention of Vitamin A Deficiency and Xerophthalmia. Prepared by a WHO/UNICEF/IVACG Task Force. World Health Organization, Geneva, 1988.
12. How to Use the HKI Food Frequency Method to Assess Community Risk of Vitamin A Deficiency, 1993. Helen Keller International, 90 Washington Street, New York, NY 10006.
13. Two Decades of Progress: Linking Knowledge to Action. Report of the XVI International Vitamin A Consultative Group Meeting, May 1995. This report is the summary of the presentations and

discussions that took place at this meeting. There are several other Vit A references listed inside the front cover.
14. IVACG Policy Statement on Vitamin A, Diarrhea, and Measles: International Vitamin A Consultative Group, 1996. Strongly recommends vitamin A supplements be included in all child survival programs as an effective strategy to reduce the consequences of diarrhea and measles.
15. IVACG on Clustering of Xerophthalmia and Vitamin A Deficiency Within Communities and Families, International Vitamin A Consultative Group, 1996.

The above references are available through:
The OMNI Project, John Snow, Inc., 1616 N. Ft. Myer Drive, 11th Floor, Arlington, VA 22209. Phone: (703) 528-7474, FAX: (703) 528-7480, Internet: OMNI_Project@jsi.com

16. Stoltzfus R, Haselow N, Kalter H. A Review of Vitamin A Messages and Curricula Used in PVO Child Survival Projects. November 1994.
17. Storms D, Quinley J, Editors. A Field Guide for Adding Vitamin A Interventions to PVO Child Survival Projects: Recommendations for Child Survival Project Managers: Report of a Special PVO Child Survival Task Force on Vitamin A, Baltimore, Maryland, 1988.

Recommended Reference Materials for Other Micronutrients
18. Dunn JT, van der Haar F. A Practical Guide to the Correction of Iodine Deficiency. International Council for the Control of Iodine Deficiency Disorders, WHO/UNICEF, 1990.
19. Guidelines for the Eradication of Iron Deficiency Anemia: A Report of the International Nutritional Anemia Consultative Group (INACG), December 1977.
20. Iron Deficiency in Infancy and Childhood: A Report of the International Nutritional Anemia Consultative Group (INACG), September 1979.
21. Guidelines for the Control of Maternal Nutritional Anemia: A Report of the International Nutritional Anemia Consultative Group (INACG), 1989.

References 19, 20, and 21, though dated, are still technically valid. They may be obtained from: INACG, 1126 16th St. NW, Wash. D.C. 20036, TEL: (202) 659-0074. FAX: 202-659-3617, e-mail: OMNI@dc.ilsi.org.

Recommended References on Home Gardening
22. Midmore, D.J., Ninez, V, Venkataraman, R., Household Gardening Projects in Asia: Past Experience and Future Directions, Asian Vegetable Research and Development Center, Technical Bulletin No. 19.
23. Marsh, R., Talukder, A, Baker, S., Bloem, M. Improving Food Security through Home Gardening: A Case Study from Bangladesh.

Recommended References on Maternal Nutrition
24.Galloway, R. and Cohn A. eds, Indicators for Reproductive Health

Program Evaluation: Final Report of the Subcommittee on Women' Nutrition, The Evaluation Project, Carolina Population Center, University of North Carolina at Chapel Hill, CB#8120, 304 University Square East, Chapel Hill, NC 27516-3997.Breastfeeding is an important crosscutting component of child survival and maternal health programs. There is evidence that exclusive breastfeeding during the early months of life provides the ideal first food for infants, decreases malnutrition, particularly when resources are scarce, confers immunity to disease, and decreases mortality. Exclusive breastfeeding, especially during the first six months postpartum, suppresses ovulation and menstruation, thereby protecting women's iron status, and allowing repletion of maternal nutrient stores. Breastfeeding is also a major biological determinant of fertility. The Lactational Amenorrhea Method (LAM) when used correctly, is as effective as the pill in clinical trials (99.5%). Finally, suckling immediately after birth reduces risk of death from postpartum hemorrhage.

For these reasons, BHR/PVC has included breastfeeding as a separate intervention in these guidelines. PVO's are encouraged to link breastfeeding and Lactational Amenorrhea Method (LAM) activities with other program interventions, such as maternal/newborn care, family planning, or nutrition/micronutrients.

Technically sound breastfeeding interventions will promote at least the following elements:

-Initiation of breastfeeding within about one hour of birth.
-Frequent, on-demand feeding (including night feeds).
-Exclusive breastfeeding until the infant reaches four to six months of age.
-LAM as an introductory method of family planning.
-Introduction of appropriate weaning foods to supplement breastfeeding when the infant is four to six months of age, while maintaining optimal breastfeeding.
-Sustained breastfeeding well into the second year of life or beyond, with gradual rather than abrupt weaning.

Programs implementing this intervention should address all of the following issues in their DIP, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information. (If the program intends to integrate breastfeeding promotion into other interventions, describe the breastfeeding component in this section, and make reference to this section in the other intervention descriptions):

1. Knowledge & Practices

Describe current breastfeeding practices in the impact area. Using the baseline survey, and qualitative assessments, give the most up to date estimates of the percentage of mothers who initiate breastfeeding within one hour of birth, give colostrum to their babies, and give nothing but breast milk for the first four to six months of life. Estimate the percentage of mothers who fail to initiate breastfeeding. For those mothers who initiate breastfeeding and stop, when and why do they stop? If the mother

works outside of the home, who cares for the infant while the mother is working?
When are supplementary liquids/foods typically introduced? Are prelacteals (substances fed to the infant prior to the initiation of breastfeeding) commonly given? What percentage of mothers are currently bottle feeding, either alone, or as an adjunct to breastfeeding?
What percentage of mothers can name one or more benefits of breastfeeding for the mother, and for the child, and what percentage know that exclusive breastfeeding is an effective method of birth spacing? What are the current attitudes and beliefs of family members, community leaders, and of staff associated with the program, towards exclusive breastfeeding? Explain how the program was able, or hopes to be able, to assess these attitudes and beliefs?
Discuss constraints, including cultural and economic, to increasing exclusive breastfeeding.

2. MOH Protocols, and Breastfeeding Related Activities in the Area
What is the MOH policy regarding breastfeeding promotion? Is there a National Breastfeeding Plan? Does the MOH have a policy on Infant Formula? Is there a National Breastfeeding Committee or Coordinator?
Describe any current breastfeeding promotion activities or organizations in the program area, such as the Baby Friendly Hospital Initiative, or La Leche League? Are there any programs in the area with policies which discourage breastfeeding? For example, if there is a supplemental feeding program in the area, is infant formula provided as a part of a food package?

3. Approach
What approach is proposed to increase breastfeeding, and how did the PVO determine this approach? What factors are in place to support or inhibit success of this approach? What are the plans to overcome the constraints? If other breastfeeding promotion activities exist in the program area, how are activities to be coordinated?
How will the program promote exclusive breastfeeding (and discourage the use of prelacteals, supplementary liquids, and foods prior to age 4 to 6 months)? If bottle feeding is a significant practice in the program area, how will the program discourage this? If counselling of mothers is included in the strategy, how will the program assure the quality of the counselling? If many mothers of young infants work outside of the home, what strategies will the program use to meet the breastfeeding needs of these infants? Will the program encourage participation of other family members, significant others, or community members in the strategy?

4. Other issues
In this section, please address each of the issues listed in section D.4 of the DIP Guidelines which you have not already discussed above (points a through h, including staff experience, training and supervision, differences from MOH policies, and the references you used).

Recommended Reference Materials
The following references, and others, are available from Wellstart International (4062 First Avenue, San Diego, CA 92103-2045. Phone 619-295-5192, FAX: 619-294-7787):

1. Community-based Breastfeeding Support: A Training Curriculum. Prepared by: USAID funded Expanded Promotion of Breastfeeding (EPB) Program. Wellstart International, 1996. (Three manuals including a planning manual, a guide for trainers and supervisors and a training curriculum.)
2. Baker, J., Huffman, S., Labbok, M, Lung'aho M, and Sommerfelt, E. Tool Kit for Monitoring and Evaluating Breastfeeding (In Draft)
3. Favin, M., and Baume, C. A Guide to Qualitative Research for Improving Breastfeeding Practices, The Manoff Group and Wellstart International, 1996.

The following materials, and others, are available from the Institute for Reproductive Health, Breastfeeding and MCH Division, Georgetown University Medical Center, 2115 Wisconsin Avenue, NW, 6th Floor, Washington, D.C. 20007 (202)687-1392:

4. The Lactational Amenorrhea Method: Are You Offering Your Clients All the Options? (Also available in Spanish and French)
5. Breastfeeding: Protecting a Natural Resource
6. Breastfeeding and Family Planning: Mutual Goals, Vital Decisions

Available from the WHO/CDD Programme, 1211 Geneva 27, Tel: 41-22-791-2633, FAX: 41-22-791-4853:

7. Savage-King, F. and Burgess, Ann. Nutrition for Developing Countries, second ed. 1992. An entire chapter is devoted to breastfeeding.The goal of this intervention is to reduce diarrhea-associated mortality and malnutrition through prompt and appropriate case management of: (a) all episodes at home with fluid and dietary management, and (b) appropriate treatment of more severe episodes by health providers.
The management of dysentery (bloody diarrhea) and of persistent diarrhea (diarrhea persisting for 14 days or more) should be included in case management protocols because these types of diarrhea are often responsible for a large proportion of diarrhea associated deaths (in spite of their low incidence).
At the household level, emphasis should be placed on the early use of available food-based fluids (but not heavily salted soups or very sweet drinks), and/or use of oral rehydration solution (ORS, if available and affordable), continued breastfeeding, small frequent feeds, catch up feeding following diarrheal episodes, and the recognition of, and prompt care seeking for, serious cases.
The use of home-made salt-sugar solution (SSS) is not recommended for most programs because the correct preparation of SSS at the household level has been found to be difficult, sometimes resulting in dangerously high concentrations of salt in the solution.

Antidiarrheal agents, and the inappropriate use of antibiotics should be discouraged. There is particular concern about the overuse of metronidazole in children at some child survival program sites, as this, along with other drugs for amoebiasis or giardiasis, are only very rarely indicated for use in children (according to current protocols, see following references).
PVOs are encouraged to promote quality improvement of case management services by supporting the training, monitoring, and/or supervision of existing public, private, and/or traditional health providers. Good communication skills on the part of all involved health workers are essential for effective case management interventions. Appropriate clinic organization, good health worker morale, and adequate supplies are important in sustaining quality case management services.
Diarrhea interventions may include diarrhea-specific preventive activities, such as education about proper disposal of the stools of young children, use of latrines, hand washing, and use of plenty of water for hygiene and clean water for drinking, if these components can be effectively implemented and evaluated.
Construction of water supply or waste disposal systems is beyond the scope of the BHR/PVC child survival program. However, if they are linked to a diarrhea case management intervention, PVOs may consider allocating part of their matching funds to these activities.
Other preventive interventions, such as breastfeeding, improved weaning practices, and measles immunization, are all recommended child survival interventions in their own right, and thus should be considered separately (and, although part of an integrated child survival approach, should be described separately in the DIP, if planned).

Programs implementing this intervention should address all of the following issues in their DIP, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

1. MOH Protocols
What is the MOH protocol for standard case management of childhood diarrheal diseases? What home available fluids does the MOH recommend, if any, and what is the content of these fluids? Include the MOH protocols for the management of dysentery and of persistent diarrhea in children.

2. Incidence and distribution
Give the most up-to-date estimates available for your program area or country for the average number of episodes of diarrhea, per year, per child. (Cite sources of data and year). During what months of the year is the incidence of diarrheal diseases highest? Estimate, with the help of the MOH or other sources, what proportion of all diarrhea is persistent and what proportion is dysenteric. Is dysentery in your program area resistant to some antibiotics? Is any information available on the importance of dysentery and persistent diarrhea as causes of death in children?

3. Knowledge & Practice

Describe current knowledge and practices of mothers in the area regarding the use of oral rehydration therapy when their child has diarrhea. Using the results of the baseline survey, estimate the percent of mothers who provide their child the same of more breastmilk than usual during the child's diarrhea. Estimate the percent of mothers who provide their child the same or more fluids (other than breastmilk) than usual during the child's diarrhea. Estimate the percent of mothers who provide their child the same or more food (other than breastmilk) than usual during the child's diarrhea. Describe current practices in your service area regarding the use of antibiotics and anti-diarrheal medications in the management of childhood diarrhea. Describe current case management protocols or practices at the health facilities, and by health workers and drug retailers, in your program area. 4. Approach

Describe your plans for this intervention. Attach your protocol for home management of diarrheal diseases in infants and children, and for the management of more severe cases, including persistent diarrhea and dysentery.

If the program will train or supervise MOH staff (and/or private practitioners or retailers) in diarrhea case management, then describe your plans for improving their case management practices. What is the quality of the case management of dysentery at the referral level?

5. ORS

If the program is promoting the use of ORS packets, describe the PVO's supply and logistics plan, and the distribution, availability, and cost of ORS packets to mothers. How will the program monitor mothers' skills in ORS preparation and use?

6. Home Available Fluids

If the program will promote the use of home available fluids, including cereal-based solutions, please list two or three widely available fluids that are appropriate to promote for the prevention of dehydration. Describe the content of any home available fluids recommended by the program.

7. Health Education

What facility-based and what community-based communication strategies will be used? What messages will you give mothers about how to administer ORS or different fluids to a child with diarrhea? What messages will you give to mothers on when to take their child to a health worker or facility? What educational methods will health workers use to talk with mothers? How will the educational sessions be organized? How will you monitor the quality of health education and measure what mothers learned about the management of diarrhea? Will the program develop or adapt any educational materials for mothers? Indicate the number of mother contacts/home visits required to reach the desired level of knowledge and practices.

8. Prevention
Will the program educate caretakers about specific ways to prevent diarrhea? If so, what will be taught, and how will these educational activities be implemented and evaluated? If planned, include a description of water supply and sanitation construction activities in this section of the proposal.

9. Other issues
In this section, please address each of the issues listed in section D.4 of the DIP Guidelines which you have not already discussed above (points a through h, including staff experience, training and supervision, differences from MOH policies, and the references you used).

Highly Recommended Reference Materials
1. The Management and Prevention of Diarrhoea: Practical Guidelines. Third Edition. World Health Organization, Geneva, 1993.
2. Management of Childhood Illness, WHO Division of Child Health and Development, and UNICEF, 1995. The IMCI ("sick child") charts and manuals for health facility clinicians include guidelines for the dietary management of persistent diarrhea, and include only four signs to assess the severity of dehydration. Otherwise, the IMCI algorithm for assessment and treatment of dehydration and dysentery is similar to the algorithm in the CDD materials.

Other Recommended Reference Materials
3. Supervisory Skills: Management of the Patient with Diarrhoea. World Health Organization, Programme for Control of Diarrhoeal Diseases, 1992.
4. Advising Mothers on Management of Diarrhoea in the Home: A Guide for Health Workers. World Health Organization, Programme for Control of Diarrhoeal Diseases, 1993 (CDD/93.1).
5. The Management of Bloody Diarrhoea in Young Children, World Health Organization, Programme for Control of Diarrhoeal Diseases, 1994.
6. Guide for Improving Diarrhoea Treatment Practices of Pharmacists and Licensed Drug Sellers. WHO.
7. Guidelines for Cholera Control. World Health Organization, Geneva, 1993.

Several of the WHO CDD documents listed above are available on the website of the WHO Division of Child Health and Development (http://cdrwww.who.ch). The website also contains an extensive reference list of WHO CDD documents, many of which are available from: The Director, Division of Child Health and Development, World Health Organization, CH-1211 Geneva 27, Switzerland (fax: +41 (22) 791-4853 or 791-0746, e-mail: WESSELL@who.ch or JosephP@who.ch). Some of these WHO documents may have been adapted for use in your country by the MOH. The vast majority of all deaths in children under five years of age associated with Acute Respiratory Infections (ARI) are due to pneumonia. However, interventions aimed specifically at reducing the incidence of pneumonia in developing countries are not yet available. General home care for children with upper respiratory infections does not

prevent pneumonia, and thus, should not be a focus of community-wide educational activities (unless specific harmful practices need to be addressed). Indoor smoke-related activities to reduce childhood pneumonia incidence (or mortality) are not recommended because studies have not yet been conducted to document the efficacy of this potential intervention. The Hemophilus influenzae type b (Hib) vaccine remains too expensive for most child survival program settings. More general preventive interventions, which may also reduce the incidence of childhood pneumonia, such as measles and pertussis immunization, breastfeeding, and improved feeding practices, are all recommended child survival interventions in their own right, and should thus be described separately in the DIP, if planned.

Thus, the only ARI-specific intervention recommended for the PVO Child Survival Grants Program is Pneumonia Case Management (PCM). The goal of the PCM intervention is to reduce mortality in children under five years of age by providing Standard Case Management (SCM) early in the illness for a large proportion of all episodes of suspected pneumonia. This is achieved by promptly providing appropriate antibiotics to children with signs of pneumonia, and by refraining from using antibiotics or other inappropriate drugs for most other Acute Respiratory Infections. The three requirements for a successful Pneumonia Case Management intervention are:

(1)Quality case management (health providers effectively trained and supervised in SCM, and supplied with adequate quantities of appropriate antibiotics);
(2)Adequate access (of households to SCM); and
(3)Essential household actions (prompt recognition of pneumonia signs, prompt care seeking from appropriate health providers, and compliance with SCM).

PVOs should implement a Pneumonia Case Management intervention only if all three of the above requirements can be adequately addressed over the course of the program.

(1) Quality case management: Quality Pneumonia Case Management means that health workers follow WHO or MOH guidelines for Standard Case Management of childhood Acute Respiratory Infections, or WHO/MOH IMCI guidelines for the Management of Childhood Illness. These guidelines include an algorithm for assessing a child with cough or difficult breathing, classification based on a few clinical signs (including fast breathing and chest in-drawing), provision of appropriate antibiotics or referral based on the classification, and counselling of the caretaker. Many health workers who have not been trained in SCM or in IMCI, or who fail to receive adequate supervision following their training, base treatment for ARI on auscultation with a stethoscope or on the presence of fever, provide antibiotics to children who are unlikely to benefit from them, provide inappropriate drugs to children with ARI, and fail to effectively counsel the caretaker about the use of oral antibiotics.

Thus, learning about current case management practices, and then providing training, supervision, and/or antibiotics to existing

public sector health workers, private practitioners, drug sellers, and/or traditional healers, is likely to be an important strategy for improving the quality of pneumonia case management services. It is important for the program to work with as many of the health providers currently treating childhood pneumonia in the program site as possible. If most childhood pneumonia cases in the area are likely to continue to be treated by providers who will not be involved in the child survival program and who do not follow good case management practices, then PCM may not be an appropriate intervention for the child survival program.

If there are malaria associated deaths in children under five, or if there is falciparum malaria transmission, in the program area, then the treatment of malaria should be incorporated in the pneumonia case management protocol to effectively address the overlapping clinical presentation of malaria and pneumonia.

Substantial hands-on practice in assessing and treating children and counselling caretakers, conducted with mothers, ill children, and small groups of trainees, should be an important part of all case management training courses. A video to demonstrate chest indrawing is also important because of the likely difficulty in finding cases of chest indrawing during training courses. All health workers who assess infants and children for pneumonia require an appropriate timing device to assess for fast breathing.

(2) Adequate access: Child caretakers are unlikely to promptly seek care from appropriate health providers after recognizing signs suggesting their child may have pneumonia if care seeking involves substantial costs in time or money. Caretakers are likely to delay care seeking from trained health workers, initially using home remedies or near-by untrained providers, and seek care from appropriate providers only after initial treatment has failed or more severe signs are recognized. Although "adequate access" is essential for reducing mortality in all areas, the definition of "adequate access" should be determined by the child survival program based on local conditions.

If much of the program site population does not have adequate access, then the child survival program should consider alternative strategies for increasing access. Providing antibiotic treatment through community health workers may be an appropriate way of increasing access, if this approach is sustainable and approved by the MOH. Several studies involving CHWs in pneumonia treatment and education of caretakers have documented substantial reductions in under-five mortality in sites with poor access to referral level care, and even in sites without access to case management services at first level health facilities. However, sustaining quality case management services through large numbers of community health workers is expensive and difficult. Thus, child survival programs should probably train as few additional workers (workers not already treating pneumonia) to provide antibiotic treatment, as possible; training only the minimum number of additional workers required to provide adequate access.

(3) Essential household actions: Pneumonia-associated deaths may occur within three to four days of the onset of lower respiratory

signs. Although most children with signs of pneumonia will recover without treatment, delays in recognition or care seeking from appropriate health providers are important causes of high pneumonia-associated under five mortality in many areas. Once treatment has been started, failure to feed a correct dose or complete a course of treatment, will increase the risk of treatment failure and the development of antibiotic resistance.
Thus, education of household members about the recognition of pneumonia and prompt care seeking from trained health workers is an essential component of the PCM intervention. Because over 30% of pneumonia-associated deaths in children under five occur within the first two months of life, and because the progression of illness in fatal episodes is likely to be particularly rapid in young infants, it is important for programs to design appropriate recognition and care seeking education strategies and messages to effectively reach all households with newborns.
Education of caretakers should follow qualitative (ethnographic) investigations of local beliefs, practices, and vocabulary related to pneumonia recognition, care seeking, and compliance with SCM. CHWs may be a good initial source of this kind of information. Community-wide educational activities regarding recognition and care seeking are appropriate only after (or in areas where) the population has adequate access to SCM.

Programs implementing this intervention should address all of the following issues in their DIP, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

Quality Case Management
1. MOH policies and activities
Briefly describe the current policies and activities of the MOH national ARI control program. Which types of providers (doctors, nurses, other health workers, volunteers, drug retailers, traditional healers, etc) does the MOH allow to give antibiotics? Does the MOH have pneumonia (or IMCI) training programs and materials for any of these types of health workers? Are the MOH protocols for the assessment and treatment of children with acute respiratory infections consistent with the WHO protocols? If not, what are the differences and the reasons for these differences?

2. Current provider practices in program area
Describe the methods and findings of any assessments of the use and quality of current pneumonia case management services in your program site. What types of health providers in your area currently provide treatment of any kind to children who may have pneumonia? Estimate the relative utilization of each type of provider (percent of all childhood pneumonia-related visits to public sector health workers, to private practitioners, to drug sellers, and to traditional healers). Estimate the percentage of each type of provider trained in standard case management for ARI (or in IMCI). Are adequate quantities of appropriate antibiotics available to these providers? How often are these providers

supervised regarding their pneumonia case management practices? Do you know how consistent their case management protocols and practices are with the WHO and/or MOH protocols?
Describe your plans for learning more about the case management practices of providers currently treating pneumonia. Will program staff assess provider knowledge about pneumonia case management, observe practices, conduct exit interviews with mothers, or monitor antibiotic supplies? What kind of tools will be used (questionnaires, checklists, clinic records?), and how will the information gained be used to improve the quality of case management?

3. Involvement of workers not currently treating pneumonia
Do you plan to provide pneumonia related training to any kinds of workers (such as community health workers) who do not currently treat childhood pneumonia? If so, describe the responsibilities these workers will have regarding pneumonia case management. Will these workers provide antibiotics for children with pneumonia? If so: how many will be trained in PCM, is this approach approved by the MOH, and how sustainable is it after the end of USAID funding? If these workers will not use antibiotics, then explain how they can have an effective and credible role in pneumonia case management even though they do not have antibiotics.

4. Training program
For each type of worker to be trained, briefly describe the training methods and materials to be used, and the number of hours of the PCM course. How much time will be devoted to practicing assessment and treatment of children and communication with mothers in clinical sessions with sick children and their mothers? How will the program ensure that trainees have gained adequate knowledge and skills?

5. Assessment
For each type of provider you will be training, which signs will lead to antibiotic treatment for infants under two months of age, for older infants, and for 12 to 59 month old children, and which signs will result in referral to a higher level of care? Include cut-offs for fast breathing for each of the three age groups. How will children be assessed for fast breathing? How will workers be trained to recognize chest indrawing?

6. Malaria
Estimate the proportion of under-five mortality associated with malaria, and/or the extent of falciparum malaria transmission, in your program area. If applicable, describe how all categories of program-associated staff who assess or treat children with fever or respiratory infections will deal with the overlap in the clinical presentation of malaria and pneumonia. Describe how children with fever, cough, or difficult breathing will be assessed and treated (including which drugs will be used).

7. Antibiotic treatment
Which antibiotics will different types of health workers provide

for pneumonia? Describe your plans for follow-up of cases under treatment to monitor the success of treatment. How will you define a treatment failure, and how will these be managed? How will health workers determine whether referred cases will promptly seek care at the referral facility, and what will be done when referral is not feasible for a family?
Can you estimate how many total courses of antibiotics all providers/workers in your area will give for pneumonia per year per child under five, on average? (In other words, what is your expected rate of treatment for pneumonia?)
Will antibiotics be sold to parents or provided free of cost? Will the program help insure an adequate supply of antibiotics? If so, how will antibiotic supplies be maintained following the end of USAID funding for the program? If not, what will be done if providers run out of antibiotics?

8. Supervision
How will newly trained workers receive continuing supervised practice in case management? How will the program monitor and improve the quality of case management services provided by each type of health worker? How will the program insure that providers use antibiotics appropriately? Briefly describe the nature and frequency of supervisory contacts, and the tools to be used.

Adequate Access
9. Current access
Mark on a map of your program site each type of provider currently treating childhood pneumonia with antibiotics, if this is helpful in understanding current access. Estimate how much time and money it currently costs people from different areas of the program site to reach and use the services of their nearest providers of antibiotic treatment for pneumonia. (Include two-way travelling costs in time and money, waiting time at providers, and purchase of antibiotics and other fees.) Are there differences in the level of access on different days of the week or at different times of the year? Are there other important problems in your area which relate to access (such as language differences between population and providers)?

10. Definition of adequate access
How much time and money does the program think it reasonable to expect families to spend to travel to/from and use pneumonia treatment services? (Define what level of access you consider "sufficient" in terms of time and money, to allow caretakers in your program area to promptly seek and use case management services.) Estimate the percentage of the target population which currently has this sufficient level of access to treatment, or identify those areas/groups which do not have sufficient access.

11. Increasing Access
Describe what (if anything) the program will do to increase the level of access. Will the program increase the availability or reduce the cost of antibiotics, or increase the number of providers able to treat pneumonia with antibiotics? Mark any planned

additional providers, along with those currently providing treatment, on a map of your program site, if this is helpful in understanding how you will increase access. Estimate the percentage of the target population which will have an adequate level of access to treatment following the training or supply of additional workers.

Essential Household Actions

12. Beliefs, practices, and vocabulary

Briefly describe the methods which you have used to gather information about local beliefs, practices, and vocabulary related to pneumonia recognition, care seeking, and compliance with treatment. Briefly discuss what you have found regarding the following issues, and/or your plans for investigating these issues in the near future. Have you identified local words for fast breathing, difficult breathing, chest indrawing, and stopped feeding well (in a young infant)? Are these signs recognized by caretakers and considered serious? Which pneumonia related signs lead caretakers to seek help outside of the household, how promptly is care sought, and from whom is help obtained? Who makes decisions in the household about when and from whom to seek outside care? Are caretakers satisfied with the care they are receiving from the providers who currently treat childhood pneumonia? What are the barriers in your area to prompt recognition, prompt care seeking, and compliance with treatment? Describe any other important information the program has gathered regarding local beliefs, practices, and vocabulary related to pneumonia recognition, care seeking, and compliance with SCM.

13. Communications for recognition and care seeking

What will be the objectives of your communications effort regarding pneumonia recognition and care seeking? Will you focus your communications efforts at any specific groups at high risk of death from pneumonia (such as young infants), or at any groups less likely to promptly seek appropriate care? Do you already know which key messages the program will emphasize regarding recognition and care seeking for older infants/children and for young infants? How will this information be communicated to mothers and other household members? Who will do this communication, when will it be done, and how often will it be done? How will the program develop and test messages and materials, and monitor the quality of this communications effort and its impact on caretaker knowledge and practices?

14. Counselling for antibiotic use and home care

Which key messages will the program emphasize regarding antibiotic use and home care for children with pneumonia? Who will do this counselling, when will it be done, and how will it be done? How will the program monitor the quality of counselling? How will you monitor compliance with treatment during follow-up of children receiving antibiotic treatment? How will you define compliance failure, and what will be done in cases of compliance failure?

15. Other issues

In this section, please address each of the issues listed in section D.4 of the DIP Guidelines which you have not already discussed above (points a through h, including staff experience, training and supervision, differences from MOH policies, and the references you used).

Recommended Reference Materials

1. Pneumonia Care Assessment Methods Toolbox. The Johns Hopkins University PVO Child Survival Support Program, 1996 (draft). Tools designed for PVO CS programs to assess the quality of PCM services, access to PCM, and local pneumonia related beliefs, practices, and vocabulary. Largely adapted from, but much more appropriate for the project site level than, the WHO ARI Programme Health Facility Survey and Focussed Ethnographic Survey.
2. The Management of Acute Respiratory Infections in Children: Practical
Guidelines for Outpatient Care. WHO, 1995. Case management guidelines for staff managing children with ARI in first-level health facilities and their supervisors.
3. Outpatient Management of Young Children with ARI: A Four Day Clinical Course. WHO, 1992. A package for training physicians, nurses, nurses' assistants, and other health center staff.
4. Management of Childhood Illness, WHO and UNICEF, 1995. The IMCI ("sick child") charts and manuals for health facility clinicians include the same basic algorithm for the detection and treatment of pneumonia in older infants and children as the algorithm in WHO ARI documents for outpatient facilities (references 2 and 3 above). However, the IMCI materials include a more complex algorithm for "possible serious bacterial infection" in young infants instead of the simpler more pneumonia-specific algorithm in the ARI documents. The IMCI materials also address the overlap in the clinical presentation and treatment of malaria and pneumonia in more detail, and exclude the management of wheezing.
5. Treating Children with a Cough or Difficult Breathing: A Course for Community Health Workers. WHO, 1992. This package includes: An ARI Programme Manager's Guide, A Course Director's Guide, A Teacher's Guide, Learner's Materials, and a video of pneumonia signs. The simplified algorithm in these documents is more appropriate for CHWs than the complex ARI or IMCI algorithms for clinicians.
6. Acute Respiratory Infections in Children: Case Management in Small Hospitals in Developing Countries: A Manual for Doctors and Other Senior Health Workers. WHO, 1990 (WHO/ARI/90.5).
7. The Overlap in the Clinical Presentation and Treatment of Malaria and Pneumonia in Children: Report of a Meeting. WHO, 1992 (WHO/ARI/92.23). Available on the worldwide web at: http://cdrwww.who.ch.
8. Technical Bases for the WHO Recommendations on the Management of Pneumonia in Children at First-Level Health Facilities. WHO, 1991 (WHO/ARI/91.20).
9. PVO Child Survival Technical Report, Volume 5, Number 1. The Johns Hopkins University PVO Child Survival Support Program, April 1997. This issue is devoted to ARI/PCM.

10. Sazawal S, Black RE. Meta-Analysis of Intervention Trials on Case-Management of Pneumonia in Community Settings. Lancet 1992; 340: 528-33. Focusses on the mortality impact of PCM trials, mostly using CHWs. Includes references for the original papers concerning nine different studies in developing countries.
11. Case Management of Acute Respiratory Infections in Children: Intervention Studies. Report of a Meeting. WHO, 1988 (WHO/ARI/88.2). Similar to the above document, includes more discussion of programmatic issues, but excludes recent trials.

The website of the WHO Division of Child Health and Development (http://cdrwww.who.ch) contains an extensive reference list of WHO ARI documents, many of which are available from: The Director, Division of Child Health and Development, World Health Organization, CH-1211 Geneva 27, Switzerland (fax: +41 (22) 791-4853 or 791-0746, e-mail: WESSELL@who.ch or JosephP@who.ch). Some of these WHO documents may have been adapted for use in your country by the MOH.

Please note that "Facts for Life" is NOT recommended as a source of messages for parents on ARI, for PVO child survival programs.The goal of the malaria intervention is to reduce malaria associated mortality and morbidity in children and pregnant women. Malaria interventions are appropriate for areas where the disease makes a substantial contribution to under-five mortality. Plasmodium falciparum, the parasite responsible for most malaria-associated deaths, affects children in three ways: acute malaria illness, chronic or persistent malaria parasitemia with anemia, and perinatal malaria infection in the mother, which can cause low birth weight and increased infant mortality.
Three different approaches to malaria control may be supported by the child survival program: (1) improved Malaria Case Management (MCM); (2) antenatal prevention and treatment of malaria through the regular presumptive treatment of asymptomatic pregnant women, or through chemoprophylaxis; and (3) reduction in malaria transmission through the community-wide use of insecticide-treated mosquito nets, including provision for regular retreatment of the nets. Malaria Case Management is an essential component of any malaria control program; only if this is being adequately addressed by the child survival program, or by others, can the two other interventions of antenatal prevention and treatment, and/or insecticide treated mosquito nets, be considered.
Activities that will not be supported include: (1) large-scale insecticide spraying operations or environmental engineering measures, both of which are beyond the scope of this program; (2) community-wide administration of antimalarial drugs, including mass chemoprophylaxis for children; and (3) environmental measures of limited effectiveness, such as clearing of brush and filling in ponds and ditches around houses.

Malaria Case Management: The requirements for a successful MCM intervention are the same as those for pneumonia case management (quality case management, adequate access, and essential household actions). In the home, early recognition and care-seeking for

episodes of fever, completion of a full course of treatment, and further care-seeking if the child develops signs of severe disease, are essential. Providers of antimalarial drugs (including shop owners, drug peddlers, and health personnel) should be encouraged to provide a full course of an appropriate drug and information on correct drug dosages, and to refer children with signs of severe disease to health facilities. Health facility-based personnel should diagnose and treat patients with malaria promptly with an effective antimalarial drug and provide supportive care, treatment of anemia, patient education, and referral in cases of severe disease where appropriate. Because of the overlap in clinical presentation of both conditions, all malaria case management protocols must incorporate assessment and treatment for pneumonia.

Antenatal prevention and treatment of malaria may increase birth weights and reduce maternal and fetal morbidity and mortality. Women who are pregnant for the first time are at greatest risk for complications arising from malaria. These women may not attend antenatal services with the same frequency as other pregnant women, especially if they are unmarried or very young. The traditional policy of pregnant women taking weekly chloroquine prophylaxis is no longer effective in many countries because of the increasing prevalence of chloroquine resistant strains of P. falciparum. Where there is widespread drug resistance, PVOs should select an alternative treatment protocol in consultation with the Ministry of Health. For example, in Malawi the Ministry of Health now recommends the administration of a full course of treatment with pyrimethamine - sulfadoxine (Fansidar) twice during pregnancy.

Insecticide-treated mosquito nets have been shown to reduce the transmission of malaria, improve health and growth rates in children under 5, and reduce child mortality. However, treated nets will not be an effective intervention if most of the malaria transmission is occurring at a time (e.g. early evening) or place (e.g. outside the house, in the forest) when people are not under their nets. Nets that are regularly treated with a pyrethroid insecticide have been shown to be far more effective than untreated nets. This is because of the repellent and insecticidal effects of the insecticide, and because torn and damaged nets still provide protection if they have been treated with insecticide. PVOs, therefore, should promote the use of insecticide-treated nets and their regular retreatment, and should not promote the use of untreated nets. In countries where use of untreated mosquito nets is already high, programs may only need to introduce insecticide treatment of nets. If malaria transmission is confined to only part of the year, it may be possible to treat the nets once a year instead of every six months. Cotton nets are less suitable for insecticide treatment because the insecticide is absorbed into the interior of the fiber. PVOs should establish a sustainable system for ensuring regular retreatment of the nets at the community level after funding ends.

Programs implementing this intervention should address all of the following issues in their DIP, or explain why an issue is not

relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

Malaria Case Management

1. Impact of malaria in the community

What is the estimated level of malaria-related morbidity and mortality among children in the program area? How is this estimate made? What proportion of children are estimated to have chronic or persistent malaria with anemia? How is this measured? Describe the seasonality of malaria and malaria-related morbidity and mortality in the program area.

2. Case management policies and availability of appropriate drugs

What are the MOH policies and protocols for the management of malaria in health facilities and by community health workers? How is malaria being managed in the home? Are there appropriate MOH policies related to the overlapping presentation of malaria and pneumonia? What antimalarial drugs are available in health facilities, grocery stores, markets, and private pharmacies? Describe the pattern of drug resistance in the program area and whether alternate drugs are available and affordable.

3. Knowledge and practices related to recognition and treatment of malaria.

Do mothers in the program area consider malaria a problem for children and for themselves? Who do they consult, or where do they take their children when they suspect malaria (to a health facility, a registered pharmacy, a community health worker, or a private clinician, drug seller, or traditional healer)? What is the local terminology used for severe and non- severe malaria that may influence decisions in treatment seeking behavior? Are there any local terms for conditions with symptoms compatible with severe malaria, for which people may seek traditional treatments in the home or from traditional healers instead of modern antimalarial drugs? Describe traditional practices for the treatment of malaria episodes in children at home. Describe any other important local beliefs and practices concerning malaria. What are the most important social, economic, and/or cultural barriers to malaria management and prevention in your area? Will the program undertake any further qualitative or ethnographic studies concerning the malaria intervention?

4. Approach to improving case management by health providers and in the home

Describe the current case management practices of health workers and of shop keepers in your area, and your planned malaria case management approach. How will the program collaborate with the MOH in implementing the malaria component? How will the program monitor and improve the quality of malaria case management practices of health workers?

What will be taught to mothers, to shop keepers, and to health workers about the recognition and management of malaria? Attach the program’s protocol for the case management of malaria at all

levels (including how the overlap in the presentation of malaria and pneumonia will be addressed by all those who assess or treat children for malaria or fever).
What methods will you use for educating caretakers? Will the program teach caretakers how to treat malarial attacks with over-the-counter drugs or train storekeepers in malaria treatment? How will the program ensure that shops sell appropriate drugs, proper dosages, and full courses of treatment?

Antenatal Prevention and Treatment of Malaria
5. Impact of malaria in pregnancy in your program area
What proportion of pregnant woman are infected with malaria, based on information from local hospitals, antenatal clinics, or from community surveys? What proportion are anemic? How common are complications of malaria in pregnancy in local health facilities?

6. Drug treatment or prophylaxis protocol
What is the current Ministry of Health policy on antenatal treatment and prophylaxis? If your organization plans to use an alternative protocol, is this acceptable to the MOH? What is the pattern of drug resistance in your area? What drugs are available? Based on this information, what drug treatment or prophylaxis protocol will you use for malaria in pregnancy?

7. Plan for providing malaria treatment or prophylaxis to pregnant women
What proportion of pregnant women visit an antenatal clinic? What special efforts will be made to reach women pregnant for the first time? Is there potential for combining administration of tetanus toxoid or other antenatal services with implementation of your protocol? How will you provide malaria treatment and/or prophylaxis to pregnant women? How does this fit in with your overall plan for providing maternal and newborn care?

8. Acceptability and feasibility of the protocol
The following questions should be addressed for both mothers and health workers who will be providing antenatal services: Is malaria or anemia recognized as a complication of pregnancy, and are the proposed drugs acceptable? Why? How would you address their concerns if they are not acceptable? What other health communication activities will you carry out to promote acceptance of this protocol?

Insecticide-Treated Mosquito Nets
9. Appropriateness of treated mosquito nets for the prevention of malaria
What mosquito species are known to transmit malaria in your area? What information is known about the time and place that these mosquito species bite? Where are people, and in particular young children, when these particular mosquito species are biting? Does malaria transmission occur throughout the year, or only during certain months?

10. Availability of nets and insecticide

Are any nets currently available for sale in your area? What material are they made of? Are nets produced locally? Is there a system for distribution and sales of the nets within the country? If appropriate nets are not locally available and your organization plans to import them, what are the associated costs (taxes, fees etc.)? What insecticide, dosage, and frequency of retreatment have you chosen? Has this insecticide been registered for public health use in your country?

11. Acceptability and feasibility
What is known about current use of untreated nets, including the proportion of houses with nets, who in the household uses nets, and seasonal patterns of net usage? What is known about acceptability of insecticide treatment of the nets? Discuss likely constraints to the success of mosquito net activities and approaches to overcome these constraints. What is your communication strategy for promoting nets, and for promoting regular retreatment of these nets? What channels of communication will be used (local women's groups, village health workers, etc.)?

12. Implementation and sustainability
Describe how the program will organize the purchase, distribution, and retreatment of the mosquito nets. What plans do you have to ensure that the mosquito net program reaches children under five years of age? How much will the program charge for nets and for retreatment, and how will this financing be organized? If either nets or insecticide will be sold at subsidized prices, who will pay for these subsidies when the program ends? What local institutions will be involved in implementing and sustaining the intervention, e.g. rural credit schemes, agricultural cooperatives, health facilities, local shop owners, district and village governments? Is this program being coordinated with other mosquito net programs being implemented in the country e.g. with regard to choice and import of insecticide and nets, and communication and financing strategies etc.?

13. Other issues
In this section, please address each of the issues listed in section D.4 of the DIP Guidelines which you have not already discussed above (points a through h, including staff experience, training and supervision, differences from MOH policies, and the references you used).

Recommended General References on Malaria Control

1. Management of Childhood Illness, WHO Division of Child Health and Development, and UNICEF, 1995. The IMCI ("sick child") charts and manuals for health facility clinicians include guidelines for the management of fever in areas of low and high malaria risk.
2. Addressing the Challenges of Malaria in Africa. USAID and U.S. Department of Health and Human Services. (Recent undated document.) Available from ACSI- CCCD Technical Coordinator, International Health Program Office, Centers for Disease Control and Prevention, Atlanta, Georgia 30333, Fax: (404) 639-0277.
3. Global Malaria Control Strategy. PVO Child Survival Technical

Report, Vol.4, No. 1, January 1994. This document contains several helpful references.
4. Health Education for Malaria Control in the Context of a Primary Health Care Approach: A Training Program Guide. August 1990. Available from ACSI-CCCD Technical Coordinator, International Health Program Office, Centers for Disease Control and Prevention, Atlanta, Georgia 30333, Fax (404) 639-0277.
5. Oats SC, et. al., Editors. Malaria: Obstacles and Opportunities. A Report of the Committee for the Study of Malaria Prevention and Control: Status Review and Alternative Strategies. Institute of Medicine, Division of International Health. Published by the National Academy Press, Washington, DC, 1991. ISBN 0-309-04527-4
6. A Global Strategy for Malaria Control. WHO, Geneva, 1993.
7. Implementation of the Global Malaria Control Strategy. Report of a WHO Study Group on the Implementation of the Global Plan of Action for Malaria Control, 1993-2000.
8. McCombie S.C. Treatment seeking for malaria: A review and suggestions for future research. Resource Papers for Social and Economic Research, Resource Paper No. 2. Can be ordered from WHO/TDR, Document no. TDR/SER/RP/94.1
9. Mwenesi H., Harpham T., Snow R.W. Child malaria treatment practices among mothers in Kenya. Social Science and Medicine. 1995; 40(9): 1271-1277.

Recommended References on Specific Aspects

Malaria Case Management and Drug Resistance

10. The Overlap in the Clinical Presentation and Treatment of Malaria and Pneumonia in Children: Report of a Meeting. World Health Organization, Malaria Unit, 1992 (WHO/MAL/92.1065).
11. Bloland P. B. Lackritz E. M. Kazembe P. N. Were J. B. Steketee R. and Campbell C. C. Beyond chloroquine: implications of drug resistance for evaluating malaria therapy efficacy and treatment policy in Africa. Journal of Infectious Diseases. 1993; 167(4): 932-7.
12. Campbell C. C. Challenges Facing Malaria Therapy in Africa. Journal of Infectious Diseases. 1991; 163(6): 1207-11.
13. Breman J. G., Campbell C. C. Combating severe malaria in African children. Bulletin of the World Health Organization. 1988; 66(5): 611-620.
14. Mwenesi H.A., Harpham T., Marsh K., Snow R.W. Perceptions of severe malaria among Mijikenda and Luo residents of coastal Kenya. Journal of Biosocial Science. 1995; 27: 235-244.
15. Ofori-Adjei D., Arhinful D.K. Effect of training on the clinical management of malaria by medical assistants in Ghana. Social Science and Medicine. 1996; 42(8): 1169-1176.

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16. Steketee, R., Wirima, J. Malaria Prevention in Pregnancy: The Effects of Treatment and Chemoprophylaxis on Placental Malaria Infection, Low Birth Weight, and Fetal Infant and Child Survival, American Journal of Tropical Medicine and Hygiene, 55: 1 Suppl. (1996): Entire volume (16 articles).
17. Helitzer-Allen H.L., Macheso A., Wirima J., Kendall C.

Testing strategies to increase use of chloroquine chemoprophylaxis during pregnancy in Malawi. Acta Tropica. 1994; 58: 255-266.

Insecticide-Treated Mosquito Nets: Effectiveness

18. Bermejo A, Veeken H. Insecticide-impregnated bed nets for malaria control: a review of the field trials. Bulletin of the World Health Organization 1992; 70: 293-296.
19. Choi HW, Breman JG, Teutsch SM, Liu S, Hightower, AW, and Sexton JD. The effectiveness of insecticide-impregnated bed nets in reducing cases of malaria infection: a meta-analysis of published results. American Journal of Tropical Medicine and Hygiene. 1995; 52: 377-382.

Insecticide-Treated Mosquito Nets: Choice of insecticide

20. Miller JE, Lindsay SW, Armstrong JRM, Schellenberg L, Adiamah M, Jawara M, Curtis CF . Village trial of bednets impregnated with wash-resistant permethrin compared with other wash resistant pyrethroid formulations. Medical and Veterinary Entomology. 1995; 9: 43-49.
21. Curtis C.F., Myamba J., Wilkes T.J. Comparison of different insecticides and fabrics for anti-mosquito bednets and curtains. 1996; 10: 1-11.

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24. Winch, PJ., Makemba, A.M., Kamazima, S.R, Lurie, M., Lwihula, G.K, Premji, A., Minjas, J.N. and Shiff, CJ. Local terminology for febrile illnesses in Bagamayo District, Tanzania, and its impact on the design of a community based malaria control programme. Social Science and Medicine, 1996: 42; 1057-1067.The purpose of the maternal and newborn care intervention is to identify those problems likely to be most responsible for increased maternal and/or newborn mortality in the program site, and to implement activities appropriate to the setting that will decrease maternal and/or newborn deaths.

Although few PVOs will be able to measure maternal mortality, some PVOs can implement activities to reduce maternal deaths. Prompt recognition of danger signs and emergencies, prompt care seeking, and adequate access to health facilities capable of effectively intervening in obstetric emergencies are essential for reducing maternal mortality. Thus, any program which aims to reduce maternal mortality should include efforts to improve prompt recognition and care seeking, and/or improve the quality of, and access to, emergency obstetric care.

Other prenatal, delivery, postpartum, and/or newborn care activities may be implemented to improve maternal and newborn

health and reduce newborn mortality, but are unlikely to have a substantial impact on maternal mortality.

Maternal Care Providers and Birth AttendantsThe program may work with health facilities to improve access, improve the referral system, and address quality of care issues, to create a favorable maternal care environment. The program may work with midwives, traditional birth attendants, or community health workers, to improve skills in prenatal, delivery, postpartum, and/or newborn care. Depending on the setting, the program may also provide education and training to family members on danger signs, hygienic births, and obstetric first aid.

Prenatal Care

All pregnant women are at increased risk for life threatening health problems. However, screening for risk factors in pregnancy will not predict most life threatening situations for either the mother or the newborn, and most women with risk factors will not experience obstetric emergencies. Because of this low sensitivity and low specificity of screening criteria, the identification and referral of high risk pregnancies should be reserved for only those programs where specific risk conditions can be addressed with concrete and appropriate interventions.

The prenatal period should be used to plan for possible emergencies with the mother, with other family members, and with the mother's providers of prenatal and delivery services. This should include education to recognize danger signs indicating obstetric complications and to recognize obstetric emergencies, identification of the specific health facility at which care should be sought, and planning for transportation to this facility. During the prenatal period, the mother, and those providing delivery services to the mother, should also be educated about the care of newborns. In addition, programs may wish to provide education regarding maternal nutrition and early and exclusive breastfeeding.

Child survival programs may promote, provide directly, or support other prenatal care activities, including the provision of tetanus toxoid immunization (see Immunization section) and/or iron and folate supplementation (see Micronutrient section). In malarial areas, chemoprophylaxis or periodic treatment for malaria may be included in prenatal care (See Malaria section).

Delivery and Newborn Care

Interventions to reduce maternal mortality should include activities to improve prompt recognition of danger signs and obstetric emergencies and prompt care seeking. Other activities may include: increasing community awareness concerning maternal mortality and obstetric emergencies, organizing emergency transportation services, evaluation of the quality of emergency obstetric care at health facilities, and efforts to increase the quality of these services. The essentials of obstetric care, as defined by WHO, are Caesarean section, blood transfusion, anaesthesia, medical treatment, manual procedures, and monitoring of labor.

Programs may provide training and supervision of those who attend births. Training should include instruction in hygienic birth practices, obstetric first aid during labor and delivery, and in establishing the chain of referral to the nearest facility capable of providing obstetric care. Training also should include the essential elements of newborn care including immediate crying, drying, breastfeeding, and "kangaroo" care.

Postpartum and Newborn Care
The immediate postpartum period can be used for a number of activities that benefit both the mother and newborn. The postpartum period can be used for the education and provision of family planning services to mothers (see Family Planning section). Instruction concerning care of the newborn, identification and referral for treatment of postpartum complications such as infection and bleeding, and education about breastfeeding may be included in this component. High dose vitamin A may be provided to mothers within two months after delivery (see Micronutrients section).

Possible Program Strategies
o educating women, families, and communities
o training and/or retraining maternal care providers, both professional and traditional
o mobilizing families and communities for support of pregnant women and newborns
o improving access
o improving utilization
o improving support services
o improving emergency transport
o improving quality of care:
o at household level: self care/healthy behaviors, care seeking decision making
o among TBAs: refocus TBA and family birth attendant training
o among professional maternal care providers: train and/or retrain professional midwives and others in lifesaving skills (LSS)

Possible Specific Program Activities
TBAs
ocritically analyze and redirect training curriculum of TBAs to focus on clean delivery, early recognition and referral of complications during pregnancy, labor, and postpartum, and recognition and prompt referral of maternal and newborn emergencies at birth and postpartum;
omotivate TBAs to collaborate with midwives and other maternal care providers in the referral chain; promote value of early referral to TBAs and communities;
ogradually de-emphasize training of TBAs, and emphasize training of midwives and other professional birth attendants;

Midwives and other maternal care providers
oconduct brief lifesaving skills training needs assessment;
oplan and implement in-service refresher courses on lifesaving skills, essential obstetric care, and early recognition of

pregnancy complications during ANC for all maternal health care providers - midwives and physicians from both public and private sector, and other types of maternal care providers;
oplan and implement in-service refresher training in counselling skills, and health education content for safe motherhood, especially recognition of danger signs and preparing a birth plan (trained birth attendant, clean delivery, use of safe birth kit, early recognition of and compliance with referral for complications, and early postpartum care); promote importance of home based maternal records (HBMR) as part of client-focused ANC;
omotivate midwives and other maternal care providers to improve understanding of cultural dynamics of community/TBA relationship and acceptance of TBA referrals;

Physicians
oconduct training refresher courses in EOC surgical and diagnostic skills;
odevelop mechanisms for improving overall quality of maternal and newborn health care, especially essential obstetric care;
prioritize review of standards and protocols using Mother Baby Package;
oestablish routine maternal and newborn death audits to determine specific weaknesses in care delivery and reduce delays in receipt of lifesaving care;
oemphasize a team approach to reducing maternal and newborn deaths and importance of collaboration and communication throughout referral network to identify and address "medical barriers" to improved maternal and newborn care;
oprovide a regular opportunity for exchange of new information about effectiveness of maternal care components and required changes in role of each level of maternal care provider; and new concepts such as integrated care;

Community
oqualitative research: identify community needs, priorities and preferences for maternal care services and practices; determine acceptability and "conditions of acceptance" for proposed interventions prior to implementation
oidentify the role of "gatekeepers" at household and community level; and develop strategies to enlist support of gatekeepers in reducing delays, reducing maternal and newborn deaths, and improving maternal health;
oprioritize identification of the local dimensions of and contributing factors to community level delay in seeking care; and systematically addressing each factor programmatically;
opromote early recognition of maternal and newborn danger signs; compliance with timely appropriate referral; importance of clean delivery and developing a "birth plan";
oimprove the community "image" of maternal health services if qualitative research shows that dissatisfaction with care is a major factor in non-utilization;

Programs implementing this intervention should address all of the following issues in their DIP, or explain why an issue is not

relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

1. Intervention Goals
State the program goals (if any) for this intervention that relate to the reduction in maternal mortality. State the program goals for this intervention that concern a reduction in newborn mortality.

Current Situation
2. Baseline information
What is the maternal mortality ratio (maternal deaths per 100,000 live births) in the program area/country? Cite sources. Describe the important findings of the maternal care sections of the baseline survey.
Describe as exactly as you can (including traveling times), what would take place if a women in your program area had an obstetric emergency, and had to be transferred to a facility that could provide the essentials of obstetric care (as defined by WHO). If there are differences between different locations in the program area, describe if you wish, the best and the worst case scenario.

3 Prenatal Care
What prenatal care facilities (e.g., prenatal clinics, health centers) and services are currently available in the program area, and who provides these services? Which of the following prenatal care services are available in the area: identification of problem pregnancies; detection of danger signs in pregnancy; malaria prophylaxis; vitamin and iron supplementation; tetanus toxoid immunizations; weight monitoring; blood pressure monitoring; detection and treatment of STDs and urinary tract infections; other?

4. Delivery/Emergency Care
What intrapartum delivery care facilities are available in the program area (e.g. hospitals, health centers, clinics, delivery huts/homes, other)? What is the quality of these services, and are they utilized by the community? Are the essential elements of obstetric care available in the area? Who provides these services? What referral and transport capabilities for obstetric emergencies are available in the program area?

5. PostPartum Care
What post partum services (e.g. detection and treatment of postpartum infections, breast feeding difficulties, nutrition advice, family planning services) are currently available? Who provides these services?

6. Constraints
What are the main constraints to prenatal, delivery, and postpartum care in the program area?

Planed Program Intervention Activities

7. Maternal Care Providers and Birth Attendants

From the baseline survey, list the following birth attendants and what percentage of births are attended by each type: trained biomedical professional (nurse, midwife, or physician); TRAINED traditional birth attendant; UNTRAINED traditional birth attendant; husband or other family member; none (the mother herself); or other (specify).

How many TBAs do you estimate attend how many births? (Are a few TBAs each attending many births, or are many TBAs each attending only a few births?) If a large number of TBAs attend births in the program area, then discuss the implications of this for your plans regarding this intervention.

Describe the group or groups that are being targeted for training, and how the training of the targeted group addresses the list above. What curriculum is used to train the groups described? How have the "Gold Standards for Maternal Care" (published by the PVO CSSP) been incorporated into the curriculum? Describe the supervisory system for the different types of attendants who frequently attend births.

8. Prenatal Care

In what aspects of prenatal care will the program be involved (ie. training personnel to provide clinical prenatal care services, or promoting prenatal care, or educating pregnant women via home visits or group meetings, other)?

Will the program be training personnel to actually provide prenatal care? If yes: (1) Who will be providing the prenatal care, and where will the prenatal care be delivered? (2) How many visits will women be expected to make, and when during the pregnancy will they be expected to make them? (3) What will be the content of the prenatal care? (4) Will tetanus toxoid be provided? Provide details of the tetanus immunization program. (5) Will Iron, Folate, or Malaria prophylaxis be provided? Explain. (6) Will urine dipstick protein uria be done? (7) Will women be weighed and blood pressure taken? How will this information be used? (8) Will the gestational age be approximated, and what methods will be used to do this? How will this information be used? (9) Will the prenatal care provider be trained to determine the presentation (ie head first, breech) of the fetus, and take action if it is breech or transverse lie? What action will be taken? (10) Will infections be identified and treated? Describe. (11) Will risk factors be identified? If so, list each one and describe the action to address each specific risk factor. For each risk factor and its action, describe the benefits the mother and child can expect to receive by following the actions suggested.

If the program is not providing prenatal care, but is promoting prenatal care and educating mothers and family members, health workers, or others: (1) Describe the promotion program, including the types of media that will be used. (2) Describe the messages women will be given that promote prenatal care. (3) Describe the risk or danger conditions that mothers, village health workers, family members, and others will be taught about. Describe what they will be taught to do if these conditions occur. (4) Describe the screening procedure health workers will perform to identify

women with problems. Describe the problems that will be screened for, and what actions will be taken if problems are found. (5) Describe to whom and where pregnant women will be referred when problems are identified. (6) What other activities will be included in prenatal care? Provide details.

9. Delivery and Newborn Care

Will the program be training personnel to deliver babies? If yes: (1) What curriculum will be used? (2) What life-saving skills (LSS) will be taught? Describe the components of the training program teaching LSS that, if performed, will serve as obstetric first aid? (such as nipple stimulation and fundal massage). (3) Describe the immediate care of the newborn the birth attendant will be trained to give. (4) How will trained birth attendants be monitored/supervised?

Will the program be educating family members about delivery and emergency care? If so: (1) What messages will be delivered about routine delivery care? (2) What danger signs will be taught? (3) What actions will family and community members be taught to take if these danger signs occur?

10. Emergency Obstetric Care

(1) How will the birth attendant handle a complication or emergency? (2) What is the chain of referral the birth attendant will use to get help? Describe in detail the communication system (if any) and the emergency transportation system that is available. If there is no emergency transport system available, describe how emergency transport could be set up in the future. (3) Describe how the program intends to develop a relationship with the referral facility to improve the quality of care of its maternal care services. How will the program prepare the referral facility to accept women with obstetric emergencies?

11. Postpartum Care

Does the program intend to provide postpartum care services? Describe how the program will provide education for post partum women. Will community health workers make post partum visits? How, when, and by whom will the following post partum problems be identified and addressed. (1) Post partum hemorrhage. (2) Post partum infection. (3) Post partum breast problems. (4) Post partum breastfeeding problems. (5) Post partum contraceptive needs. (6) Post partum wound healing problems. (7) Post partum nutritional counseling.

12. Documentation

Please attach a copy of the MOH Mother's Card, or a copy of a card or other record keeping document that the program intends to use to keep track of maternal care provided. What will be done if the mother's card is lost?

13. Other issues

In this section, please address each of the issues listed in section D.4 of the DIP Guidelines which you have not already discussed above (points a through h, including staff experience,

training and supervision, differences from MOH policies, and the references you used).

Highly Recommended Reference Materials

1. Morrow H, and Anderson F. Gold Standards in Maternal Care Curricula for Use by PVO Child Survival Projects. Johns Hopkins University School of Hygiene and Public Health, PVO Child Survival Support Program, 1995.
2. A Review of Maternal Care Messages and Curricula Used in PVO Child Survival Projects. The Johns Hopkins University Child Survival Support Program, May 1995. This document contains a bibliography with 12 references appropriate for PVO child survival programs. Major areas of concern identified in this recent review include: the lack of distinction between danger signs and risk conditions, the lack of concrete follow-up actions when problems are identified, care of the newborn and postnatal care, and the failure of programs to evaluate maternal care training programs and the quality and content of messages for mothers.
3. Moore KM. A Brief Background Paper and Suggested Revisions for the Detailed Implementation Plan Guidelines for USAID PVO Child Survival Projects: Maternal and Newborn Care Component. Draft, 8/28/96. Available from BHR/PVC.
4. Mother Baby Package: Implementing Safe Motherhood in Countries. WHO, 1994. This practical guide for the implementation of maternal and newborn care activities includes a broad range of potential maternal care activities (many appropriate for very rural and isolated settings) with corresponding objectives and strategies for achieving the objectives. Contains a complete WHO Safe Motherhood Resource list.

Other Recommended Reference Materials

5. Mothers and Child Survival: Lessons Learned in Adding Maternal Health Interventions to PVO Child Survival Projects. This publication includes recommendations from the 1992 PVO Maternal Lessons Learned Conference in Shiprock, New Mexico.
6. Training of Traditional Birth Attendants (TBAs). WHO. Includes a guide for master trainers, a guide for TBA trainers, and an illustrated guide for TBAs.
7. The Warmi Project: A Participatory Approach to Improve Maternal and Neonatal Health, An Implementors Manual.
8. Management of Obstetric and Neonatal Emergencies in Community Health Centers.
9. Training Manual for Trainers of Traditional Birth Attendants.
10. Life-Saving Skills Manual for Midwives.
11. Management of Life Threatening Obstetrical Emergencies.
12. Obstetric Management Protocols for Regional-Departmental Hospitals.

References 1, 2, and 5 are available from the PVO Child Survival Support Program, 103 East Mt. Royal Ave., Baltimore, MD 21202. Tel.: (410) 659-4100.

References 4 and 6, and other safe motherhood materials, are available free of charge from the Division of Family Health, WHO,

1211 Geneva 27, Switzerland. Tel.: 41 (22) 791-2111. Fax: 41 (22) 791-0746. Telex: 27821.

The Mothercare Project/John Snow Inc. has published references 7 - 12 and many other excellent monographs and training manuals appropriate for PVOs to use in strengthening community involvement and training, and improving quality of care. These are available from Mothercare, 1616 North Fort Myer Drive, 11th Floor, Arlington VA, 22209. Tel.: (703) 528-7474 The purpose of the child spacing intervention is to allow mothers in the program area to space their pregnancies as far apart as they wish, and prevent unwanted pregnancies, thus decreasing maternal and under-five mortality. PVOs are encouraged to work with existing providers in the program area to improve the quality of services. A quality family planning program comprises the following six key elements:

- Choice of family planning methods (including availability of methods, variety of methods available, and ease of referral)
- Information and counseling given to clients (provide information about methods, ensure client understands the information, and counseling of service providers)
- Technical competence (staff skills and training, availability of service protocols, availability of technical support, and level of hygiene and infection control)
- Interpersonal relations (client-provider communications, and respect, understanding, and truth shown to client)
- Mechanisms to encourage continuity (adequate client follow-up, information about return visits, and positive provider-client relationship)

To ensure a successful family planning program, it is important that contraceptive commodities be available in the right place at the right time and in the right quantities. A well-functioning contraceptive supply system is essential and, if not already established in the program area, must be addressed. Elements of this process include:

- Forecasting contraceptive needs.
- Maintaining adequate supplies of contraceptives.
- Identifying contraceptive suppliers.
- Storing contraceptives.
- Record keeping for contraceptive supplies.

For PVOs proposing the actual delivery of family planning services, two service delivery models to consider are community-based distribution (CBD) and clinic-based services. They can be used alone or in combination, depending on available resources and on community needs. A variation of these two basic service types is the mobile clinic that offers clinic-type services at regular intervals to remote communities. Mobile services can also support community-based distribution by offering a referral point and by resupplying Community-Based Distributors.
Programs should consider targeting intervention activities at those groups most in need of family planning, and/or at those most likely

to use the services. For example, women who have recently had a child, and who want no more children in the next two years, but are not using modern contraceptives, may be effectively reached through post-natal visits.

Programs implementing this intervention should address all of the following issues in their DIP, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

1. Baseline information

What information exists concerning family planning in the program area? Using the results of the baseline survey, what percent of mothers do not want another child in the next two years, or are not sure, are using a modern contraceptive method? Include estimates of contraceptive prevalence, drop-out rates, and unmet need (and discuss the source of information). What do mothers think about the current quality of family planning services in the area?

2. Current Family Planning Services and Constraints

Briefly describe the national family planning policies and program. Describe the services and facilities currently available in the program area, including the number and types of trained providers, the current commodity supply, distribution, and storage system, and available counseling and referral systems. What group or groups are currently providing contraceptive services in the area? What family planning services are currently accessible to women in the program area? Are contraceptive commodities easily available? Describe the current mechanism for obtaining contraceptives for women wishing to use them. What are the main constraints to family planning. Describe constraints to: (1) maintaining a supply of contraceptive commodities, (2) educating women about family planning, and (3) making contraceptives easily available.

3. Approach

In what family planning activities will the program be involved? Which of the following family planning activities will the program implement? (1) Promoting family planning. Describe the promotional campaign. (2) Education about family planning techniques. Describe who will do the education, how the educators will be trained, and what they will teach. (3) Identifying men and women who desire family planning services. Describe who will do the identification, how they will be trained, and what will be the next step for the couple, once identified. (4) Distributing family planning commodities. Describe what commodities will be made available, how they will be distributed, and how the procurement of the contraceptive commodities by the couple will be guaranteed over time. (5) Maintaining a constant supply of family planning commodities.

For both temporary and permanent methods, how will the quality of services be monitored and improved? Will both men and women participate in activities for the promotion of birth spacing? If yes, please describe. Describe the relationship between approaches

implemented through community-based workers, and those carried out by clinic-based practitioners. How will the family planning intervention be linked to government family planning policies and programs.
Attach the program's family planning curricula for each level of worker. What key messages will the program use regarding family planning? How were these messages developed and tested? Describe and/or attach the program's documentation method for the family planning intervention.

4. Other issues
In this section, please address each of the issues listed in section D.4 of the DIP Guidelines which you have not already discussed above (points a through h, including staff experience, training and supervision, differences from MOH policies, and the references you used).

Highly Recommended Reference Materials
1. Integrating Family Planning Into NGO Programs, Joyce V. Lyons and Jenny A. Huddart, John Snow, Inc., Family Planning Service Expansion and Technical Support (SEATS) Project, 1996.
2. Pocket Guide for Family Planning Service Providers, Paul D. Blumenthal and Noel McIntosh, JHPIEGO Corporation, 1995.
3. Family Planning Lessons and Challenges, Making Programs Work. Population Reports, Series J, No 40, August 1994. The Johns Hopkins University Center for Communication Programs, 111 Market Place, Suite 310, Baltimore, MD 21202-4024

Other Recommended Reference Materials
4. Family Planning Counseling: A Curriculum Prototype (Participants Handbook), AVSC International, 1995.
5. The Family Planning Mangers’s Handbook: Basic Skills and Tools for Managing Family Planning Programs, Wolff, J. A. et al., Management Sciences for Health, 1991.
6. Family Planning Logistics Guidelines, Centers for Disease Control and the Family Planning Logistics Management Project, John Snow, Inc., 1993.
7. Handbook of Indicators for Family Planning Program Evaluation, Bertrand, J.T. et al., The Evaluation Project, Chapel Hill, 1994.
8. Bulatao RA, Levin A, Bos ER, Green C. Effective Family Planning Programs. World Bank, Washington DC, 1993. (103 p.)
9. Mauldin WP, and Sinding SW. Review of Existing Family Planning Policies and Programs: Lessons Learned. Population Council, New York, 1993. (working paper No 50, 49 p.) Available from: The Population Council, International Programs, 1 Dag Hammarskjold Plaza, NY, NY 10017.The goal of the STI/HIV/AIDS intervention is to prevent the spread of HIV through education and motivation for behavior change. It may also be appropriate to carry out, or to support, condom social marketing or distribution, referral for HIV/Sexually Transmitted Infections (STIs), informed voluntary counselling and HIV testing, and/or other prevention, care, and support activities.
This intervention is most appropriate for PVO child survival programs in areas with a high prevalence of STIs, and/or a rapidly

increasing prevalence of HIV infection. HIV/AIDS activities are more likely to be successful if program staff include those with prior experience with this work. These activities also are best carried out in sites where the PVO has earned the trust and confidence of the community in a well established health or child survival program.

Proposing a relatively small effort (for example, less than 15-20% of a child survival program budget) for a complex new activity such as HIV/AIDS, usually is only justified if it is clearly linked with other related efforts, has strong community and political support, and does not overtax staff and resources committed to other proposed program interventions.

Targeting increases in knowledge usually is only justifiable if local studies have shown low levels of understanding of the basic facts about HIV/AIDS. More often, knowledge of the facts is adequate, but motivation, skills, and resources to change high risk behavior and situations are needed.

It is critical that appropriate referral sources be available in response to the demand created by educational efforts. All proposed activities should be culturally acceptable and consistent with the host country HIV/AIDS policies and strategies.

The intervention should have well-defined audiences, include participation of these audiences in planning, implementing, and evaluating HIV/AIDS activities, and collaborate with local counterparts. Because of the importance of STIs in the transmission of HIV, PVOs are encouraged to include activities to interrupt the transmission of STIs. The syndromic approach, a relatively quick and effective way to diagnose and treat STIs in men, should be considered. When combined with better drug supply, and with the "five C's of quality care" (confidentiality, condom supply, counselling, compliance with treatment, and contact tracing), the syndromic approach can make STI services more widely available through primary care clinics.

Programs implementing this intervention should address all of the following issues in their DIP, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

1. Baseline information

What is the approximate prevalence and trend of HIV infection in the adult population in the program area and/or in other similar areas and populations of the country? Cite sources. If known, state the approximate prevalences of other STIs in the program area or region. What is the prevalence of positive syphilis serologies (blood tests) among women or among pregnant women in the program area?

Describe the relevant knowledge, beliefs, attitudes, and practices of adolescent and adult women and men in the program area related to the transmission and prevention of HIV infection. Include attitudes toward male and female fidelity, fertility, and family planning, and attitudes towards other STIs and regarding tuberculosis, if known.

What are the key factors that facilitate, or could facilitate, the spread of HIV infection in the program community? Describe the relevant findings from the HIV/AIDS portions of the baseline survey.

2. MOH Policies and current activities in area

What are the focal areas of national policy related to HIV/AIDS? Are mandatory reporting regulations in place and enforced? Can the confidentiality of sero-status be guaranteed? Are there up to date national guidelines for the diagnosis and treatment of STIs? What are the government regulations regarding partner notification and/or contact tracing?

What reproductive health services are available in the area? What is the prevalence of modern contraceptive use? Are condoms available? Through what kind of outlets, and at what cost?

Describe any activities related to HIV/AIDS prevention, care, and support that are currently under way (by any group) in the program area.

3. Approach

Are program staff currently involved in any HIV/AIDS-related activities? What existing activities or skills of program staff, if any, will facilitate including an intervention for HIV/AIDS in the program? If the HIV/AIDS intervention is a new activity for them, what do program staff feel will be the effect of implementing an HIV/AIDS-related intervention on how the child survival program is perceived in the community? If negative community perceptions are anticipated, then what de-stigmatization strategies are planned?

Describe the planned HIV/AIDS component of the program. Include the general strategies that will be used (e.g., develop and teach locally appropriate strategies for negotiating risk reduction with sexual partners; increase skills of program beneficiaries to use condoms and/or negotiate other forms of "safer sex”; establish sustainable systems to distribute condoms at community level), and describe the activities that will be carried out.

Will the program train personnel to provide HIV/AIDS prevention, care, and/or support services? If yes, describe who will be trained, for what activities, and how they will be supervised. Include details of the training plans and concerning plans for quality control and referral. Will technically adequate anonymous or confidential HIV counselling and testing be available? At what cost?

If the program is addressing other STIs, such as gonorrhea, then describe these activities. Will treatment for STIs be available in response to demands created by educational efforts? Will the program use the syndromic approach for STIs?

What do staff feel to be the main obstacles to carrying out an effective HIV/AIDS intervention in the program area? How will the program address the obstacles to the successful implementation of HIV/AIDS activities?

What key messages will the program include in communicating with each beneficiary group regarding HIV/AIDS prevention, care, and/or support? How were these messages developed and tested? How, and

in what setting, will these messages be conveyed to each group?

4. Other issues
In this section, please address each of the issues listed in section D.4 of the DIP Guidelines which you have not already discussed above (points a through h, including staff experience, training and supervision, differences from MOH policies, and the references you used).

Highly Recommended Reference Materials1. Mercer MA, Munz M, Editors. Including HIV/AIDS Prevention Activities in PVO Child Survival Projects. Task Force Report. PVO Child Survival Support Program, The Johns Hopkins University School of Hygiene and Public Health, Department of International Health, Baltimore, Maryland. June 1995. This publication includes additional references useful for Program Managers.
2. Controlling Sexually Transmitted Diseases. Population Reports, Series L, No 9, June 1993. Johns Hopkins University Center for Communication Programs, 111 Market Place, Suite 310, Baltimore, MD 21202-4024.

Other Recommended Reference Materials
3. Lamptey P, Tarantola D, Netter T, editors. Handbook for AIDS Prevention in Africa. Family Health International, 1990. Available from: Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709.
4. HIV/AIDS Strategic Action Plan for Asia. U.S. Agency for International Development, Bureau for Asia, Washington, DC, June 1993.
5. AIDSCAP handbooks: (a) How to create an effective communications project, (b) How to conduct effective pretests, and (c) Assessment and monitoring of BCC interventions. Available from AIDSCAP, 2101 Wilson Blvd., Suite 700, Arlington VA, 22201. Phone: (703) 516-9779, Fax: 516-9781.

United States Agency for International Development
Bureau for Humanitarian Response
Office of Private and Voluntary Cooperation
PVO Child Survival Grants Program

Guidelines for Preparation of
Detailed Implementation Plans

August 7, 1997

The Detailed Implementation Plan (DIP) is the PVO's workplan, which describes in detail the plans for implementing the child survival program, and serves as the basis for future evaluation of the program's success. The DIP should be based on collaborative work at the field level, and should then be reviewed and approved by the PVO's headquarters before it is submitted to USAID. DIPs should be submitted to BHR/PVC within six months of the program start date (except for Entry Grants), following guidance to be provided in the future. Please do not submit a DIP with a grant application. DIP TABLE OF CONTENTS

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ATTACHMENTS

Annex I.Response to proposal review comments
Annex II. Baseline survey report
Annex III.Response to final evaluation recommendations (if applicable)
Annex IV.Scope of work of sub-contractor (if applicable)
Annex V. -(Other attachments, as required)Section A. FIELD PROGRAM SUMMARY

Complete Table A: Field Program Summary, and insert in the DIP after the table of contents.

Section B. PROGRAM GOALS AND OBJECTIVES

Complete Table B: Program Goals and Objectives, summarizing the program's overall goals and measurable objectives for each intervention, and insert in the DIP after Table A.

Section C. PROGRAM LOCATION

C.1 Location Maps
Include (after DIP Table B) a readable map which shows the location of the program impact area(s) relative to other regions of the country, and another map of the program area itself. Label towns and give a scale. If possible, indicate existing hospitals, health centers, clinics, and/or health posts.

C.2 Location description
Describe the precise program location. Indicate whether there is more than one impact area. Include socioeconomic characteristics of the population, such as economy, religion, status of women, ethnic groups, literacy, etc. Identify potential geographic, economic, political, educational, and cultural constraints to child survival activities which may be unique to this location.
Provide estimates of the mortality rates of infants, children, and mothers in the area, and on the distribution of these deaths by cause, if data are available. Briefly describe the current health infrastructure, staff, and interventions of the program area.

Section D. PROGRAM DESIGN

D.1 Summary of overall program design
Briefly describe your overall program design, including the specific child survival interventions. Provide the rationale for the choice of the program design and interventions in relation to the causes of death in the area and the strengths and weaknesses of existing health services in the area. List the groups targeted for program activities and define high risk populations for each intervention. Describe the process by which eligible women, children and newborns will enter and participate in the program. Briefly discuss the relationship to the child survival program of any other non-BHR/PVC funded interventions which you are implementing in the child survival program site which are related

to the CS program in an important way.D.2 Collaboration and formal agreements
Describe existing and planned collaboration between the program and health and development organizations, and the current status and substance of agreements with governmental departments and other organizations that are important to the program. Is any financial exchange or knowledge transfer anticipated? If another organization is sub-contracted to help implement this program, then please enclose its scope of work as an annex to this DIP.
Identify the in-country organizations with which the program collaborated on the development of this DIP. Identify community leaders or community groups that worked with you on the development of this DIP.

D.3 Technical assistance
If the program plans to obtain technical assistance for specific interventions or other components, state the source and schedule of technical assistance planned for each intervention, as far as currently planned.

D.4 Detailed plans by intervention
Describe in greater detail your plans for each USAID funded child survival intervention that the program will implement. The DIP should contain a separate section for each of these interventions. Each of these intervention-specific sections of your DIP should address all of the issues and questions raised in the intervention-specific annex of these guidelines ("Technical Reference Materials and Guidance for Preparation of Detailed Implementation Plans by Intervention"). While addressing the intervention-specific points in your DIP, please ensure that the following issues are also clearly addressed in each of the intervention sections:

(a)Intervention-specific experience of program-associated staff (of the PVO and collaborating organizations), and if staff lack experience with the intervention, how intervention-specific knowledge and skills will be increased.
(b)Baseline survey results and/or any qualitative/ethnographic findings concerning local beliefs and practices related to the intervention.
(c)Current government, NGO, private, and traditional services, protocols, and practices in the program area related to the intervention, and the strengths and weaknesses of these existing services.
(d)How program activities will complement, and be implemented in cooperation with, these existing organizations and services. Who will do what?
(e)Intervention-specific training for each type of health worker, including training objectives, training content, and number of training hours to be provided for health workers for each intervention for both initial and refresher training, amount of time trainees will spend in field or other practice sessions and plans for evaluating health worker training.(f) How the program will monitor and improve the quality of all major intervention activities (including those implemented in cooperation with other

organizations). The methods and frequency of supervision related to the intervention.
(g)If any intervention activities proposed differ from MOH policy, or from accepted international practice (according to the references cited in these guidelines), then describe these differences, and why they are justified.
(h)Identify the reference materials you used as the technical basis for planning the intervention and for writing the intervention-specific section of the DIP. Include the year of publication.

If BHR/PVC is funding any interventions other than those covered in the intervention-specific annex, then please discuss your plans for this intervention and address points (a) through (h).

D.5 Innovations which may be scaled up
Describe any innovations, new methods, strategies, or materials you plan to implement or develop, which may be used or applicable on a wider scale in the future. Have you had any discussions with the MOH concerning the possibility of the program implementing any innovations on an experimental basis, which if successful, could be adopted by the MOH?

D.6 Schedule of field program activities
Complete a workplan for the life of the program, that includes a calendar of major activities and persons responsible, including, if applicable, a schedule for phasing-in geographic areas and/or interventions. (Please insert this workplan in the DIP following the "Innovations" section.)

Section E. HUMAN RESOURCES

E.1 Organizational chart
Attach an organizational chart. Include all types of staff who will be providing child survival services (such as community health workers) and their supervisors. On the chart, state the names and titles of your key in-country program staff; including each person responsible for (1) program administrative management,
(2) oversight of technical health activities, (3) monitoring of progress toward objectives, (4) training of health workers and (5) the health information system. Indicate whether the staff member is expatriate or host country national; full or part-time; salaried, volunteer, or seconded from another agency. E.2 Health workers
Identify the total number of health workers by type, including volunteers, for all types of health workers who will provide child survival services. How many of these workers were already active or previously trained prior to program implementation, and how many were or will be recruited by the program? What organizations, other than this program, do these workers work with or for?
Describe the duties related to the child survival program of each type of health worker. How many hours per week will each type of health worker be expected to devote to CS program related activities?
What is the ratio of health workers to the number of families or to

the number of beneficiaries? Compare the staffing pattern for the child survival program with that in other similar non-program areas. How much more intensive, in terms of the types and numbers of health workers used, is the program compared to the MOH? Explain why the program has decided to work with these types and numbers of health workers.
What percentage of the workers and/or volunteers do you expect will have to be replaced every year? Discuss what you expect the reasons will be for worker replacement, and what the program will do to minimize the rate of replacement.

E.3 Supervision plan
How will the program monitor and improve the performance of all types of health workers associated with the program? Describe the persons responsible for supervision of the health workers, the frequency at which different types of health workers will be supervised, the ratio of supervisors to health workers, and number of supervisors for the program.

E.4 Community committees and groups
If the program works with health committees, community groups, mothers clubs, or women's savings groups, indicate the person(s) responsible for liaison with the groups, and the frequency of program contacts with these groups. What is the total number of each type of group that will be involved in the program? What are the responsibilities of each type of group? How frequently in a year should each group meet?

E.5 Role of country nationals
Describe the role of country nationals in management of this program. Discuss short and long term plans for enhancing their skills in planning, budgeting, accounting, personnel management, financial management and computer use.

E.6 Role of headquarters staff
Name the individual(s) from the PVO/regional office and PVO/USA office who is (are) responsible for technical backstopping of this program. How many visits to the program will be made each year? Approximately how many days will each visit will consist of? What will be the main purpose of the visits?

Section F. PROGRAM MONITORING HEALTH INFORMATION SYSTEM

F.1 HIS plan
Discuss how program progress will be monitored. Will you track individual beneficiaries and the services provided to them over time (census-based tracking of individuals), and/or will you monitor program activities and services provided to beneficiaries (service, activity, or contact-based reporting)?

F.2 Data variables
Specify which data variables you will collect to monitor the program, how this data will be collected, from whom it will be collected, how often it will be collected, and by whom. Describe

any qualitative (ethnographic or non-quantitative) data collection which you plan to do on a regular basis.

F.3 Data analysis and use
Describe plans for data analysis, use, and dissemination to program staff, the community, MOH authorities, and the PVO home office. How will the program use data collected on specific variables to improve the coverage or quality of intervention activities?

F.4 Other HIS issues
How will you protect the confidentiality of personal health data? Identify the materials and equipment that are needed for the HIS. Describe the program's needs for technical assistance, if any, in developing the HIS. State when the program HIS will be fully operating.

Section G. SUSTAINABILITY STRATEGY

G.1 Sustainability goals, objectives, and activities
Specify what the program expects to leave in place at the end of the child survival grant. What continued financial or other support from community beneficiaries, the MOH, an indigenous NGO, other local organizations, or other donors, is necessary to continue or sustain activities after USAID/BHR/PVC child survival funding ends? What are your plans for getting key collaborating health and development agencies involved in planning for sustainability? Describe your sustainability goals, objectives, and activities (following the example table in these guidelines if you wish).G.2 Community involvement
Describe the plans for community involvement in planning for sustainability. What are the community's priorities? What evidence do you have that community members want child survival services? How will the program encourage continued public involvement in program activities?

G.3 Phase-over plan
If you plan to phase over major program responsibilities and control to other institutions, what evidence is there that these institutions will sustain program activities? When will the phase-over occur? What is your plan for strengthening the program management skills of staff in these institutions so they can better sustain activities?

G.4 Cost recovery
What, if any, cost recovery strategies will be explored during this program? How do you plan to evaluate the feasibility and acceptability of your cost recovery strategies? Provide the name and title of the person with overall responsibility for implementing the program cost recovery strategies. Identify any technical assistance that will be obtained to help design cost recovery activities.

Section H. BUDGET

The budget may be excluded from your DIP if there have been no changes in the program's site, selection of interventions, or number of beneficiaries, which would result in changes to the budget of your cooperative agreement that was negotiated with the Office of Procurement. If there have been changes, then please submit revised forms 424 A and B (following the instructions enclosed herewith).ANNEX I. RESPONSE TO PROPOSAL REVIEW COMMENTS

Attach as an annex a narrative explanation of how the DIP responds to each "concern" submitted to the PVO as a result of the proposal's technical review. If you reject, or address any "concern" in a different way than suggested in the proposal review, then please explain your reasons for this. Please reference other sections of your DIP which address the "concerns," instead of repeating in this section what you have written elsewhere.

ANNEX II. BASELINE SURVEY REPORT

Submit a full report of the baseline survey process, tools, and results as an attachment to the DIP. Be sure to include numerators, denominators, and percentages for intervention indicators/objectives. If changes in the objectives have been made as a result of baseline survey results, list in two columns (1) the original objectives as previously submitted and (2) the revised objectives determined as a result of the baseline survey. Summarize the input of the MOH and community groups into the design and implementation of your baseline survey, and describe how those same groups were involved in using survey findings in the design of the program.

ANNEX III. RESPONSE TO FINAL EVALUATION RECOMMENDATIONS

If this is a DIP for a follow-on program and a final evaluation has been completed since the submission of a proposal for the current funding cycle, then please attach as an annex a narrative explanation of how the program is addressing each of the recommendations made in the report of the final evaluation. Please reference other sections of your DIP which address the recommendations, instead of repeating in this section what you have written elsewhere.

ANNEX IV. SCOPE OF WORK OF CONTRACTOR

If another organization (such as a local NGO, or another PVO) is a partner in this program, please describe that organization's responsibilities.DIP TABLE A: FIELD PROGRAM SUMMARY

PVO/Country: _____

Cooperative Agreement No.: _____

Program Duration (from/to mm/dd/yy): _____

1. PROGRAM EFFORT AND USAID FUNDING BY INTERVENTION

Intervention% of Total Effort (1)USAID Funds in $
(2)Immunization%$Nutrition/Micronutrients%$Breastfeeding Promotion%$Control of Diarrheal Disease%$Pneumonia Case Management%$Malaria Control%$Maternal and Newborn Care%$Child Spacing%$STI/HIV/AIDS Prevention%$Others (specify)%$Total100%$
(1)Estimate the percentage of total effort (from USAID and PVO match funding) the program will devote to each intervention to be implemented.
(2)Estimate in US dollars (not in percent) the amount of USAID funding (excluding PVO match funds) the program will devote to each intervention.

2. Program Site Population: Children and Women (3)
Population Age GroupEstimated Number in Age GroupInfants (0-11 months)12-23 Month Old Children24-59 Month Old ChildrenTotal 0-59 Month OldsWomen (15-49 years) (4)
(3)Estimate the number of people in the age group that the program expects to serve. Do not add annual births. If the program is phasing-in geographic areas over time, then estimate the population to be covered by the end of this funding cycle (after all areas have been phased-in).
(4)Estimate the number of women if data is available.EXAMPLE DIP TABLE B: PROGRAM GOALS AND OBJECTIVES

Program GOALS: 1. To decrease the mortality of children under 5 years of age.
Program Objectives by Intervention Measurement Methods for ObjectivesMajor InputsMajor OutputsMeasurement Methods for OutputsIncrease from 60% to 80% the number of children 12 - 23 months completely immunizedKPC Survey - Baseline and End of Program1. Training course for MOH personnel
2. Design cold chain monitoring system
3. Develop vaccination strategy1. Trained vaccinators
2. Reliable cold chain
3. Increased number of children vaccinated per session1. Pre and post tests, training records
2. Monthly check on cold chain log
3. Monthly check on MOH EPI cards

EXAMPLE DIP TABLE: SUSTAINABILITY GOALS, OBJECTIVES, AND ACTIVITIES
Sustainability GoalsObjectivesActivities Required
1) MOH will take on health promotive activities of CS program1) MOH will supervise and provide refresher training for 50 CHVs

2) Health officer will meet monthly with community health committees1) 2 MOH nurses trained in CHV supervisory methods

ANNEX D

USAID 22 CFR PART 226

BHR/PVC PVO CHILD SURVIVAL GRANTS PROGRAM

(Computer Address:
http://www.info.usaid.gov/ftp_data/pub/handbooks/cfr22/)

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Bureau for Humanitarian Response

Office of Private and Voluntary Cooperation

STRATEGIC PLAN
1996-2000
(Abbreviated version)

September 1996

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PVC STRATEGIC PLAN

The Strategic Plan developed by the Office of Private and Voluntary Cooperation (PVC) in the Bureau for Humanitarian Response (BHR) reflects the values and practices promoted by the reengineering initiative of the U.S. Agency for International Development (USAID). Teamwork and the involvement of PVC's partners in the U.S. private voluntary organization (PVO) community were integral to its development. The product reflects their shared objectives.

Part IIntroduction

A.Overview of the Role of PVC in the Agency

PVC plays a dual role in USAID. Through the programs it administers, PVC provides direct support to efforts made by the U.S. PVO community and by its local partners to address critical needs in developing countries and emerging democracies. Within USAID, PVC also serves as a focal point for information about PVO

capabilities and programs. The Office is a key player in the development of policies and procedures that affect these organizations.

At the operational level, PVC's primary mission is to support capacity building which strengthens the sustainable impact potential of U.S. PVOs working in participatory, grassroots development. Through support for U.S. PVOs, PVC also aims to strengthen the capacity of local NGOs and community groups to deliver sustainable services, particularly to underserved communities. The primary way in which PVC supports its mission is through the competitive grant programs it administers. These include Matching Grants, Child Survival Grants, Cooperative Development Grants, the Farmer-to-Farmer Program, and Ocean Freight Reimbursement. PVC also administers USAID's Development Education program which provides grants to U.S. organizations to educate the American public about developing country needs and about the ways in which U.S. foreign assistance, and the efforts of the PVO community, help to address those needs. Brief descriptions of each of these programs are provided in the text box on the next page.

MAJOR PROGRAMS ADMINISTERED BY THE
OFFICE OF PRIVATE AND VOLUNTARY COOPERATION (PVC)

■Matching Grants: The Matching Grant Program assists PVOs that address development priorities which are consistent with those of USAID. It provides support for capacity building for PVOs and, through them, to their NGO partners to professionalize their management systems or technical backstopping of programs, replicate proven program approaches in new places, expand to new sectors, or undertake innovative projects that offer possibilities for transferring new skills and methods. These grants, which are matched by PVOs on a dollar-for-dollar basis, leverage private resources for development and help to strengthen the financial viability of the PVO recipient.

■Child Survival Grants: The Child Survival Grant Program works with PVOs that engage in primary health programming as part of their international development efforts. Matched by a 25 percent contribution from the PVO, Child Survival Grants support projects that are designed to have a real impact on the health status of children and mothers living in target areas in developing countries, e.g., a lower incidence of death from infant and childhood diseases. Low-cost strategies that can be sustained over time are central to these projects. In addition, capacity building for sustainable health service delivery is a standard feature in these grants.

■Cooperative Development: The Cooperative Development Program provides support to U.S. cooperative development organizations to enable them to help create or support cooperative movements in developing countries and new democracies. These grants strengthen and expand the capacity of U.S. organizations to work internationally, allowing them to provide technical assistance and

training to their local counterparts.

■Farmer-to-Farmer Program: The Farmer-to-Farmer Program provides grants to U.S. PVOs, cooperatives, NGOs, and private agribusinesses to build their capacity and defray the costs of providing direct agricultural technical assistance through U.S. volunteers to farmers, farmer organizations and businesses overseas. P.L. 480 Title II resources enable PVC to administer this popular people-to-people program.

■Denton Program: The Denton Program allows for the shipment of humanitarian aid cargo from private U.S. organizations free of charge to the donor via military transport on a space available basis. Generally, donor organizations have strong links to the in-country NGOs with which they work, providing medical equipment, educational supplies and other goods to assist local efforts for service provision.

■Ocean Freight Reimbursement: The Ocean Freight Reimbursement Program enables more than 50 PVOs each year to meet the costs of shipping supplies to developing countries in support of development and humanitarian activities. Recipients of these funds generally have a strong link to grassroots recipient organizations with which they work. Normally, there is a self-help component to all projects for which ocean freight reimbursement is provided. The Ocean Freight Reimbursement Program leverages cost-shared resources that are many times greater than the funds USAID administers; for every USAID grant dollar up to $40 in private resources are leveraged.

■Development Education: This program, which includes Biden-Pell Grants to institutions working on development education, provides Americans with opportunities to learn about developing countries, the U.S. foreign assistance program, and the work of PVOs and CDOs overseas.

PVOs and their local partners also benefit from PVC’s information and program support function including the registration of U.S. PVOs. PVC also registers local private voluntary organizations (LPVOs) that wish to work with USAID Missions overseas. In addition, PVC monitors the degree to which U.S. PVOs are maintaining their private funding base.

PVC fulfills its liaison and information functions for other offices within the Agency on both the policy and operational levels. PVC provides information on PVO capabilities and programs to the public as well as to USAID operating units. PVC also helps to promote better integration of PVO programs with USAID Mission strategies. It does so primarily through the grant program guidelines the Office issues which require Mission comment and clearance on all proposals to ensure that the PVO programs funded by PVC are consistent with Mission Strategic Objectives. On the policy level, PVC plays a key role in the development of Agency policies that focus on the USAID-PVO partnership. PVC's

involvement in policy formulation ranges from the broadest levels, e.g., on USAID's New Partnerships Initiative (NPI), to operational guidance for program managers, e.g., on cost-sharing requirements, to addressing issues that affect PVOs in the area of procurement policy. PVC also contributes to the policy dialogue in its role as the Secretariat for the Agency's Advisory Committee on Voluntary Foreign Aid (ACVFA).

B.Scope and Organization of the Strategic Plan

PVC views this Strategic Plan as a landmark. Consistent with USAID's reengineering directives, the process used to develop this plan was highly participatory, involving all of the Office's staff as well as a significant number of representatives of the PVO community. While PVC's Strategic Plan does not specify all of the actions the Office will take to achieve the objectives set forth in this document, it does provide a clear outline of the direction in which PVC intends to move.

The Plan itself is divided into three parts. It is structured along the lines suggested by the Strategic Planning Guidance memorandum issued by BHR in October 1995:

Introduction (Part I). This section introduces PVC, its Strategic Plan, and the consultative process used to develop this plan.

Summary Analysis of Assistance Environment and Rationale (Part II). This section provides information on the legislative and foreign policy basis for PVC's work, the external and Agency context within which the program must operate, constraints and opportunities, and PVC's partners and customers.

Proposed Strategic Plan (Part III). This section of the document presents the Office's Strategic Plan and its Results Framework. It provides the rationale for selecting PVC's Strategic Objective and Intermediate Results. Included are discussions of the linkages to Bureau and Agency objectives, assumptions that could affect successful implementation of the plan, the role of PVC's partners, and the means by which success will be judged. Current PVC activities that support the achievement of results identified in the plan are also discussed.

C.PVC's Strategic Planning Process

PVC's Strategic Plan was developed over the past two years through a collaborative process which involved all members of the PVC staff and some BHR Program Office staff, as well as many of PVC's PVO partners. Highlights of this planning process included:

■Teamwork at the Office level on early efforts to conceptualize a framework of results that accurately characterizes the Office's programmatic thrust;

■Collaboration with the Bureau's Program Office and BHR senior managers, which helped to ensure that the Office's plan was clearly linked to the achievement of Strategic Objectives at the Bureau level;

■Consultation with PVO partners on PVC’s Results Framework, and on the development of candidate performance indicators, as part of a two-day RFA workshop in September 1995. More than 100 of PVC’s PVO partners participated in this workshop. A parallel session was held for cooperative development organizations (CDOs);

■The establishment and continued use of expanded Strategic Objective and Intermediate Results teams, through which PVOs participated as actual and “virtual" team members in the development of PVC’s Strategic Plan; and

■Two day-long strategic planning exercises that focused on the programmatic and organizational implications of PVC’s emerging Results Framework, which involved the entire office working in teams.

As ideas evolved during this planning process, PVC staff identified important results that cut across, or derived from, more than one grant program or program support activity. Using a Results Framework approach, PVC staff were able to articulate not only the way in which the work of the Office supports U.S. PVOs, but also the manner in which PVOs reach out from these USAID-funded activities to build the capacity of local NGOs to provide critical services on a sustainable basis. Through an iterative process, PVC staff were also able to articulate the ways in which their public information and liaison functions support broad Office, Bureau and Agency objectives. As the Office’s results-oriented structure of objectives evolved, PVC staff also worked with their PVO partners to define performance indicators that could be used to measure progress and performance on each of the key objectives.

In developing this Strategic Plan, PVC made a concerted effort to apply USAID's reengineering principles. Teams that cut across traditional and bureaucratic lines were used throughout the process. Involvement of partners and customers, another core USAID value, was initiated well before the plan reached the end of its formative stage. Many ideas offered by the PVO community are now an integral part of PVC's plan.

While this process was lengthy and time consuming for all involved, its benefits are multiple and include:

■A clearer understanding on the part of individual PVC staff of all of the grant programs and activities managed by the Office;

■Improved teamwork within the Office and with many of the partner organizations with which we work; and, perhaps most important,

■A sense of “ownership” of PVC's objectives, and the performance indicators that will be used to judge our success, on the part of the partner organizations upon whom that success ultimately depends.

Part IISummary Analysis of Assistance Environment and Rationale

A.PVC’s History, Relationship to U.S. Foreign Policy, and Legislative Mandate

Established in 1977, PVC is the focal point for maintaining a productive partnership between USAID and the PVO community. For almost 20 years, PVC has been committed to:

■ Assisting the PVO community in empowering individuals in developing countries to mobilize local and outside resources to meet their needs;

■ Enhancing the capacity of U.S. partner organizations to plan and carry out overseas development programs; and

■ Supporting long-term sustainable development.

Through its three functions - grant administration; public outreach and coordination; and information and program support - PVC strengthens the public/private partnership through which the qualities and values of the American people, as embodied in PVOs and cooperatives, are incorporated into the U.S. foreign assistance program.

The international development efforts of U.S. PVOs have their basis in more than a century of humanitarian work overseas. World War II gave rise to a new generation of PVOs that were set up to meet post-war needs in Europe. After World War II, attention shifted from Europe to the developing countries. PVOs gradually broadened their programs from relief, disaster assistance and food distribution to efforts aimed at addressing the root causes of poverty and improving the quality of life. The work of the PVO community adds an important people-to-people dimension to U.S. foreign assistance efforts.

The post-war shift that engaged PVOs in efforts to address development concerns eventually led to a partnership between the PVO community and USAID. By the early 1970s, USAID and PVOs were engaged in a collaborative process and USAID was working with PVOs to implement projects overseas. Foreign aid legislation has been supportive of this relationship for over 20 years and Congress continues to direct USAID to work collaboratively with the PVO community. As indicated in Section 123 of the Foreign Assistance Act of 1961 (FAA), as amended:

“The Congress declares that it is in the interest of the United States that such organizations and cooperatives expand their overseas development efforts without compromising their private and

independent nature. The Congress further declares that the financial resources of such organizations and cooperatives should be supplemented by the contribution of public funds for the purpose of undertaking development activities in accordance with the principles set forth in this section."

This authorizing legislation includes a requirement for individual PVOs to obtain at least 20 percent of their funding for international activities from sources other than the U.S. Government. It also places a floor for USAID spending on and through the PVO community of 13.5 percent of the aggregated amount appropriated to carry out the work defined in several sections of the FAA, and there is a target range of 16 percent for certain of USAID's budget accounts. In 1995, the Clinton Administration pledged to channel 40 percent of USAID's development assistance resources through NGOs, both U.S.-based and indigenous. This commitment was made in March 1995 when Vice President Gore introduced the New Partnerships Initiative (NPI) at the Social Summit in Copenhagen. However, a target level of 40 percent has not yet been incorporated into USAID's authorizing legislation.

USAID financial support for PVO activities reached more than $1.4 billion in FY 1994, including development assistance funding, more than $700 million in P.L. 480 Title II commodities, and related ocean freight to support PVO food-based programs overseas, and $8.5 million in Denton Program shipment support. A substantial portion of the funds USAID allocates to PVOs are earmarked for work on development problems on which the U.S. Congress and USAID place a high priority.

PVC administers a small but significant percentage of these resources. Congressional discussions of PVC's funding level for PVOs are sometimes cited separately in Committee report language. Traditionally, PVC's support to the PVO community has served as a bellwether of USAID's overall commitment to the USAID/PVO partnership. In FY 1995, PVC's grant programs amounted to $51 million, of which $45.5 million was allocated to supporting PVOs and $5.5 million was focused on assistance to CDOs.

Over the years, PVC investments in PVOs have been critical to the evolution of the PVO community. Consistent with its interest in strengthening the development capabilities of U.S. PVOs, PVC has used its grant programs to encourage institutional strengthening activities within these organizations. During the 1970s and early 1980s, institutional support grants from PVC helped to facilitate the transition that many PVOs have made from providing only relief services to developing a capacity for addressing development priorities as well.

Institutional support grants have also helped PVOs to expand their work in selected sectors. PVC's Child Survival Grants have helped certain PVOs to expand their involvement in this sector and laterally increase the range of services they can competently provide. Viewed from the perspective of the PVO community, PVC has

played a vital leadership role in introducing new approaches and developing programmatic trends.

B. Overview of the Context in which PVC Operates

USAID and the PVO community operate in an environment where change is now expected. In recent years, the range of countries in which USAID and its PVO partners work has expanded to Eastern Europe and the Newly Independent States (NIS) as well as South Africa. In addition, new issues continue to arise in countries where USAID and U.S. PVOs have worked for many years. This changing environment is marked by a growing severity of complex civil emergencies. The increased frequency with which countries find themselves in transition, and the unlikely continuation of current levels of donor funding, have resulted in an increased demand for the services of PVOs and NGOs in both relief and development activities worldwide, which places an increased strain on their ability to respond to these challenges. These factors frame the fundamental challenges PVC and its PVO partners face in the design of a Strategic Plan for the period 1996-2000. The Strategic Plan PVC has developed looks to the future, but it also draws on a clear understanding of the past.

After several decades of working primarily through host country governments, USAID has recognized that development initiatives have a better chance of succeeding if they also involve citizens' organizations and encourage the private sector in developing countries. Accordingly, USAID has begun to invest in decentralized and non-governmental solutions to important development problems. This evolution, which began in the mid-1980s, is reflected today in the emphasis USAID places, in a wide range of countries, on the expansion of mechanisms that promote civil society. Work with host governments is still a priority, especially at the policy level. At the operational level, where program services are delivered, the share of USAID programs are implemented by U.S. PVOs and local NGOs is increasing.

Over the last two decades, many PVOs have become more international in character in response to the needs they see overseas and their growing capacity to deliver services and other kinds of assistance abroad. In recent years, PVOs have demonstrated that they can cost-effectively reach and assist people in virtually any country. Within these countries PVOs often work at the grassroots level at which people organize themselves to address problems and opportunities.

Despite the increased institutional maturity and technical sophistication of a number of U.S. PVOs, and their growing capacity to deliver technical assistance to NGOs, many still require significant support. This support is vital for helping U.S. PVOs and USAID to work together to meet changing priorities and new development challenges, such as the HIV/AIDS epidemic of increasingly pandemic proportions. The challenge for PVC and for the U.S. PVO community lies in finding ways to ensure that the

quality of PVO programs improves, even as these programs expand in scope and diversity. Some PVOs need to strengthen their ability to plan, while others need to improve their ability to mobilize resources, or develop procedures for monitoring the progress and impact of their programs. Looking beyond these internal improvements, many U.S. PVOs are just beginning to address the challenge of working more collaboratively with NGOs, often in unfamiliar countries under complex political circumstances.

PVO competence and experience in the range of fields and countries USAID assists have grown in organizations that have worked in this field for years. The PVO community has also expanded laterally, with an impressive number of new PVOs emerging to address the problems of specific countries or to provide new types of services in well established fields. Over the past decade, the number of PVOs registered with USAID has doubled, increasing from 143 in 1985 to 434 in 1995. The emergence of new PVOs on the international scene poses a challenge to USAID's ability to integrate these new organizations into the larger PVO partner community.
As the number of PVOs grows, the mechanisms used to link them also expand. InterAction, an organization whose members are U.S. PVOs, has emerged as a focal point for the discussion of issues of interest to many PVOs and as a channel through which PVOs can communicate with USAID and with Congress on a collective basis. Organizations and associations of this type also provide USAID with a forum in which program initiatives can be discussed.

In recent years, the growth of the U.S. PVO community has been paralleled in developing countries and emerging democracies by an unprecedented increase in the number of local non-governmental organizations (NGOs). Community action has long been a force in countries around the world, but the strength of individuals at the local level has not always translated itself into the formation of groups that attempt to pursue objectives, or the interests of their members, in systematic ways. The visible effect of the rising number of local NGOs was perhaps most noticeable in the global explosion of grassroots organizations following the end of the Cold War. While some of these local organizations focus on democratic initiatives, the focus of others ranges from health care to the provision of credit for micro- and small enterprise. In many countries, NGOs are attempting to fill in the gaps created by economic liberalization, downsized national administrations, privatization, and expanded personal and political freedom.

The growth of NGOs has proven to be a real opportunity for many U.S. PVOs, as well as a great challenge. In response to this challenge, many U.S. PVOs have begun to redefine their role and expand their sphere of influence. Rather than seeing local NGOs as competitors, U.S. PVOs are working with them to make them stronger internally and better able to deliver services on a sustainable basis. To do so, U.S. PVOs are making a dramatic adjustment in their role in the development process. They are moving away from the direct delivery of services to more of a role as intermediaries that help strengthen the capabilities of local NGOs to deliver

services and respond to the development needs of their own communities.

Over the last few years, USAID's understanding of the role that PVOs can play in supporting local, non-governmental programs increased dramatically. Within USAID, the demand for PVO involvement in efforts to strengthen NGOs has risen perceptibly. In addition to viewing local NGOs as effective program implementors, USAID is also increasingly aware of the way in which NGOs strengthen the fabric of civil society. Through U.S. PVOs, USAID helps local NGOs to empower citizens to take advantage of changes in their own environments, adding new energy to development efforts. Growth in the numbers of such NGOs means that there are very real prospects for enabling a new generation of local leaders, and entire countries, to achieve a new level of self-reliance.

The ability of U.S. PVOs to work effectively with local NGOs is one of the reasons USAID is supportive of efforts that engage U.S. PVOs as USAID's development partners. USAID's Administrator has repeatedly encouraged PVO involvement in USAID programs, and USAID policies have been updated to reflect that support. U.S. commitment to the development of a strong partnership between the Agency and the U.S. PVO community, and to the development of partnerships between U.S. PVOs and local NGOs is also supported by the New Partnerships Initiative (NPI). Interest in PVOs and NGOs has also grown among other donors, such as the World Bank, the InterAmerican Development Bank, and the European Union, who are now engaged in efforts to determine how their use of these important resources might be expanded.

USAID is also looking for new ways to expand the role of PVOs in development education. PVOs form a natural bridge between the people of developing countries and the American people. They operate at the grassroots level where services are provided and where American citizens make individual contributions to PVO programs. More effort needs to be made to identify opportunities for PVOs and CDOs to inform Americans about their development work overseas and its impact on people.

The evolution of communications technologies is supporting the changes that are taking place in PVOs and NGOs. It also supports the actions USAID is undertaking in response to its 1994 reengineering guidelines which place a high value on teamwork both within USAID and between USAID and its partners. The prevalence of faxes, e-mail and Internet access is starting to make daily contact between the U.S. and remote sites in developing countries not only feasible but affordable. These new technologies enhance the ability of PVOs to work with each other and to communicate, in an interactive fashion, with USAID.

Modern communication technologies also support the growing "internationalization" of U.S. PVOs and local NGOs by facilitating communications among members of PVO and NGO networks and associations. Professional associations of U.S. PVOs are beginning

to use the Internet to link U.S. PVOs with each other. The information sharing potential of this technology extends, in principle, to links between local NGOs and U.S. PVOs and, on a regional or national level, to communications among local NGOs through new networks and associations that are emerging or have yet to be formed.

The massive expansion of PVO and NGO capacity which is taking place responds to the tremendous needs of the developing world and an increasing demand for the services of PVOs and their local NGO partners. This growth in both demand and supply contrasts dramatically, however, with downward pressures that are affecting both bilateral and multilateral assistance budgets. As a result, USAID's explicit support for the PVO/NGO community is not being matched by a commensurate increase in the flow of resources toward these organizations and the goals they are pursuing. One of USAID's greatest challenges is how to sustain its vital support to the PVO community in the face of dramatic budget reductions.

C.Customers and Partners

PVC's situation is somewhat unique within USAID. The PVOs with and through which it works are the Office's customers, in that PVC's assistance helps to make them stronger. They are also the Office's partners, for they, in turn, help local NGOs and other local partners to become stronger by working with them to provide sustainable services to improve the lives of men, women and children in the developing world. PVO energies, like USAID's, are focused on the creation of sustainable patterns of goods and service delivery in key sectors in the developing countries and emerging democracies in which they work.

1.The Customers Served by PVC Programs

The ultimate customers, or beneficiaries, of the programs PVC administers are the people that benefit from the goods and services which PVOs and their NGO partners deliver. These goods and services support non-governmental efforts to improve health conditions, educational opportunities, and the productivity and profitability of the farms and businesses that provide people in developing countries with their livelihood. While PVC's role in reaching these customers depends on PVOs and other local intermediaries, it is nonetheless important. PVOs that receive grants from PVC deliver services, either directly or through local partners, that are of direct benefit to people throughout the developing world. Thus, for example:

■Through its Child Survival Grants, PVC supports PVOs and their partners, including NGOs, local ministries of health and community based organizations, in the immunization of children and the provision of oral rehydration salts to children suffering from dehydration due to diarrhea. Mothers are counseled concerning

disease and about the positive health effects of breastfeeding and child spacing.

■Through its Matching Grants program, PVC supports PVO/NGO efforts that deliver credit to female entrepreneurs outside of the formal banking system, which often denies them access.

PVC grant programs in these and other sectors focus on ensuring the sustainability and improvement of the kinds of services that customers receive from the U.S. PVOs and their local NGO counterparts.

Many of the customers who are affected by programs run by PVOs live in countries that face development or humanitarian assistance problems which are well known to USAID, e.g., floods, earthquakes and dysfunctional economic policies. Other customers live in countries that USAID has only recently begun to serve. These countries face problems that are relatively new to the development community, such as the challenge of building democratic institutions. The achievement of key elements of the PVC Results Framework, which is presented in Section III of this document, will allow PVC to serve its customers more effectively.

The PVOs that PVC assists, along with their partner NGOs, are also customers of PVC. Capacity improvements within these organizations are a primary benefit which these customers receive from PVC's investments. These investments, in turn, help to make PVOs more successful in affecting the ultimate customers, and better partners for the Agency as a whole.

2.PVC's Partners

PVC works in partnership with PVOs to carry out a wide range of grant programs that have developmental and humanitarian impacts. Through these organizations, PVC also works as an indirect partner in development and humanitarian programs carried out by local NGOs. As of October 1995, of the 434 U.S. PVOs registered with USAID, 130 were receiving assistance from PVC. Included in the latter number are 10 U.S. CDOs with which PVC has an ongoing relationship. The number of local NGOs and cooperative development organizations affected by these arrangements is not known at the present time, but reports from U.S. PVOs and CDOs suggest that this number is increasing and will continue to increase.

PVC has learned a number of important lessons from years of work with these development partners. With respect to its efforts to strengthen U.S. PVOs that are working on long term development problems, PVC has learned that investments in capacity building to improve the planning and management systems of PVOs, as well as those of their local NGO partners, enhance the replicability and "scaling up" of successful sustainable development programs initiated at the grassroots level. Another important lesson has

been that the support of sectoral and other PVO and NGO networks, such as the Small Enterprise Education and Promotion (SEEP) network, fosters heightened capacity in a cost-effective manner.

In addition to considering PVOs and the local NGOs with which they work to be its development partners, PVC also views the USAID Missions overseas and other USAID bureaus as partners. PVC's relationship with these Missions is becoming more collaborative, and is based on joint efforts to ensure that the PVO activities we separately fund are well integrated at the country level. PVC's partnership with USAID Missions also extends to joint efforts which aim at ensuring that country-based Strategic Plans evolve from processes that involve U.S. PVOs and local NGOs. At the policy level, PVC works closely with PPC and the Global Bureau, and views them as important development partners.

Multilateral donors, foundations and other entities that engage in development assistance work are often involved in the programs carried out by the PVOs PVC supports or by their NGO partners. For this reason, PVC considers other donors to be its development partners. In support of this partnership, PVC contributes ideas and issues to PPC's Office of Development Partners and works on selected donor coordination task forces to help coordinate the capacity building efforts supported by other donors with PVC's own programs.

Part IIIProposed Strategic Plan and Results Framework

A.Overview of PVC's Strategy and Linkage to Agency, Bureau and Mission Objectives

1.Overview of PVC's Strategy

PVC's strategic plan builds on the historical strengths and comparative advantages of the Office. For nearly 20 years, PVC's support to the PVO community has focused on the institutional capacity these organizations need to develop in order to achieve the objectives of programs they undertake in developing countries and emerging democracies. PVC's relationship with the PVO community differs from the type of relationship a USAID Mission develops with a PVO. Mission funding of PVOs is normally oriented to the implementation of development programs. To compete for this type of funding, PVOs must already have, or be engaged in ongoing efforts to build, the capacity that is needed for development work. PVC is uniquely positioned within USAID to provide this type of capacity building assistance to the PVO community. Over the years, PVC's grants have helped many in the PVO community to develop their institutional capacities to the point where they are capable of running the kinds of programs USAID Missions fund and are working effectively on the cutting edge of development in priority sectors.

In selecting its strategic objective for the period covered by this plan, PVC's aim was to focus on capacity building not as an end in itself, but rather as the means, or foundation, for ensuring that

its grant programs result in the provision of needed goods and services to people in the countries USAID assists. At the level of its strategic objective, PVC's interest goes beyond the institutional capacity of individual PVOs. What is important from a development perspective is the continuous improvement in the capability of the PVO community as a whole to respond effectively to the full range of challenges facing developing countries.

Reflecting this focus, PVC has selected a single Strategic Objective (SO) that draws together a number of critical and interconnected concerns. This objective calls for the: Increased capability of PVC's PVO partners to achieve sustainable service delivery. This objective has three interrelated aspects.

The first important aspect of this objective is its focus on improving the capacity or collective capability of the U.S. PVO community. Improvements in the capability of U.S. PVOs are viewed by PVC as being inextricably linked to service delivery improvements, irrespective of whether these services are being provided by PVOs directly or by their local NGO partners. Service delivery is the second important aspect of PVC's SO. Its inclusion in the objective statement forces PVC and its PVO partners to focus on and measure performance in these terms. The provision of goods and services does not guarantee that the kinds of development impacts USAID seeks will occur, but it is an essential prerequisite for such impact. The final aspect of PVC's SO is the expectation that services will be delivered on a sustainable basis. The delivery of needed goods and services must be organized in ways that do not depend upon perpetual support from USAID or other donors. PVC's SO is realistically limited to PVC's PVO partners. PVC directly affects only those members of the PVO community with which it is in contact. Indirectly, however, improvements that result from PVC's work with a limited set of PVOs should have a ripple effect in the PVO community as a whole.
By incorporating all of these important and interrelated aspects of PVO capability to provide sustainable service delivery into its SO, PVC is establishing a clear and direct link between the Office's work, and that of its PVO partners, and the kinds of impact that BHR and USAID are broadly seeking. For this reason, PVC has selected Sustainable development impacts in priority sectors as its Goal. This Goal is consistent with and essential for the achievement of USAID's overall aim of sustainable development.

In the process of developing this plan in consultation with its PVO partners, it became apparent to PVC that a number of PVOs have stepped away from direct service delivery and are working increasingly with NGOs and other local partners to address development priorities. While PVC wanted to incorporate these efforts to strengthen NGOs and other local partners into its Results Framework, it viewed the achievement of this type of objective as being one step beyond its manageable interest at the present time. To accommodate this situation, PVC decided to establish a separate Sub-Goal that reflects the diversity of approaches employed by PVC grantees. This Sub-Goal which is

pertinent for most but not all PVC grantee programs, aims at seeing: NGOs and other local partners strengthened. In placing this Sub-Goal along the results path that leads from the SO to the Office's Goal, PVC is saying that programs can either go through this Sub-Goal, and contribute to its achievement along the way, or they can go around it, as is the case when a PVO or CDO directly delivers services that support broad USAID objectives.

Increasing the capability of PVC's PVOs partners to achieve sustainable service delivery encompasses a systematic move away from direct service delivery by U.S. PVOs and progressively towards the enhanced service delivery capacity and increased autonomy of their local partners. Inherent in this objective is the transfer of skills and technologies to NGOs. PVC will continue to support efforts towards the "localization" of U.S. PVO country programs while at the same time placing increased emphasis on strengthening non-affiliated NGOs and local government partners. By concentrating on helping our partners "achieve" sustainable development rather than "deliver" services, we are providing "enabling" support for local transfer to happen. We have taken care to emphasize "achieve" because our partners work in a variety of ways to ensure the delivery of services. Both the concentration on PVO capacity and transfer to local counterparts are linked to achieving better service delivery.

Through matching grant guidelines for 1996, PVC began to encourage PVOs to form partnerships with local counterpart organizations using structured agreements that detail the roles and responsibilities of both parties. We are building on that foundation by calling on PVOs whose programs we support to strengthen the participation of local partner organizations in their programs. PVC has learned that many of its partner PVOs are already engaged in the transfer of skills and resources to NGOs. PVC's role in facilitating local capacity building is to assist PVOs along this path. It is at the Sub-Goal level that PVC is focusing on the important area of NGO strengthening, facilitating the inclusion of local capacity development into PVO programs and encouraging the transfer of PVO resources to local counterparts.

Supporting the achievement of its SO, and the Sub-Goal and Goal that reach beyond the level of PVC's manageable interest are five Intermediate Results (IRs), each of which contributes to the achievement of PVC's SO. These IRs build on the traditional strengths of the Office while at the same time cutting across the grant programs PVC manages in a way that PVC anticipates will be both catalytic and synergistic. The five IRs on which PVC will concentrate its efforts include:

■Operational and Technical Capacity of U.S. PVOs Improved. This IR focuses on the capacity of the individual PVOs and CDOs with which PVC works. Improvements in the professional skills of PVO staff as well as in organizational systems and the application of "best practices" are envisioned.

■Strengthened Partnership between USAID and U.S. PVOs. This IR recognizes the importance of dialogue and collaboration in the relationship between USAID and U.S. PVOs. It builds upon the catalytic role that PVC has played in promoting policy and programmatic improvements that are already being forged between the Agency and the PVO community.

■Strengthened U.S. PVO and NGO Partnership. This IR reaffirms the importance of strengthening NGO capacity and building upon the efforts that many PVOs are already making to structure partnerships that help shift the capability and the responsibility for sustainable service delivery to their NGO partners.

■Improved Mobilization of Resources by PVC's PVO Partners. This IR acknowledges the need for greater efforts on the part of the PVO community to diversify its income sources. The IR envisions steps PVC can take to assist PVOs in mobilizing the resources that will be needed to expand upon current programs and promote sustainability.

■U.S. Public Awareness Raised. This IR focuses on the responsibility that PVC and the PVO community share with respect to ensuring that the American people understand the intentions and impact of development programs, particularly those that U.S. PVOs and their local NGO partners carry out in collaboration with USAID.

PVC's Strategic Objective and the Results Framework of which it is a part reflect the Office's primary mission: to strengthen the development capabilities of U.S. PVOs. PVC's Results Framework also includes a focus on the results that actually reach people. At the SO level, the phrase "achieve sustainable service delivery" is intended to suggest the importance PVC places on seeing both PVOs and their NGO partners produce measurable service delivery outcomes. Microenterprise credit programs supported by Matching Grants, for example, should result in loans to entrepreneurs who might not otherwise have access to credit. Service delivery is a clear objective of the PVC plan, and a primary responsibility of PVC grantees, at the SO level.

A summary of PVC’s Results Framework is presented graphically in Figure 1 on the following page. At the top of this hierarchy of objectives are the Office's Goal, Sub-Goal and Strategic Objective. PVC’s SO is supported by five Intermediate Results, which are displayed in a subordinate position in Figure 1. The development hypothesis here is that PVOs and CDOs cannot increase their capability and foster sustained service delivery without better management systems and technical know-how; a strong working partnership with USAID; an equally strong relationship with their local partners; adequate financial resources mobilized by leveraging the grants they receive from USAID; and U.S. public awareness of the importance of international development.

The IRs that PVC has selected to support achievement of the Office SO are themselves complex, and all are necessary elements of a comprehensive approach. Our decision to consider these important results as IRs rather than a series of SOs derives from our vision of our mandate and our sense of how far up this hierarchy of objectives we can and should reach in defining which objectives are within PVC's "manageable interest." The SO PVC has chosen as the focal point of its Strategic Plan aptly characterizes what we believe to be the level to which we should aspire and which, from a management perspective, we have the capacity and potential to reach.

2.Linkage to Agency, Bureau and Mission Objectives

PVC's SO is directly linked to the achievement of its Goal of sustainable development impact in priority sectors, as Figure 1 displays. Achievement of PVC's SO and Goal contributes, in turn, to USAID's ability to achieve the five core objectives that define its sustainable development strategy. When PVC refers to USAID's sustainable development aims in the text of this Strategic Plan, we are implicitly referencing the Agency's five core objectives and the way in which the Office's Results Framework contributes to success in each of these areas. In the paragraphs below, each of these objectives is identified and the relationship between PVC's plan and their achievement is summarized in bullets on the following page.

■Broad-based economic growth : Strengthened PVO/NGO capacity is central to the expansion of access and opportunity within a society, which is fostered through the promotion of microenterprise and small business and the building of human skills and capacities. In addition, many local NGO partners of PVC grantees are directly involved in production and marketing, particularly in the agricultural sector, and can be excellent resources for technology transfer.

■Health and population: Effective health and population programs must be responsive to needs and problems that are defined locally and that actively involve clients as well as providers in their design, implementation and assessment. This relies heavily on the capacity of PVC's Child Survival grantees. Shipments of medical equipment through the Denton and Ocean Freight Programs complement these efforts.

■Environment: Strengthened NGO capacity is critically important because environmental solutions begin at the local level. PVC is working with U.S.

PVOs and their NGO partners through its Matching Grants program. Work in this area is also just beginning to emerge at the sub-project level within the Farmer-to-Farmer program.

■Democracy: A viable and functioning NGO sector sustains and promotes effective representative institutions. U.S. PVOs can be active partners in direct interventions that strengthen these organizations as well as promote the democratic process.

■Crisis Avoidance, Mitigation and Relief: Strengthened PVO capacity that is fostered by the kinds of development-oriented programs PVC administers also translates into improved capacity in times of crisis.

While PVC's SO has direct links to Agency-wide objectives, it also supports key element of BHR's Strategic Plan, including the Bureau's Goal of "increased participation of vulnerable groups in sustainable development" and its third, fourth and fifth SOs:

BHR SO 3:Strengthened capability of PVO and NGO community and international organizations to deliver development and emergency services;

BHR SO 4:Sustained improvements in household nutrition and agricultural productivity for vulnerable groups served by USAID food aid programs; and

BHR SO 5:BHR more effectively influences Agency integration of food security, disaster relief, and PVO/NGO collaboration in strategic planning for country programs.

In citing these elements of BHR's Results Framework, PVC is distinguishing the support it provides to the BHR plan as support that focuses on the development side of the "relief-to-development continuum."

With respect to BHR SO 3, PVC considers itself the lead office for the Bureau. Its office-level SO, which focuses on the ability of PVOs and their NGO partners to provide services on a sustainable basis, feeds directly into this bureau-level SO. PVC's contribution to BHR SO 5 is also direct and significant. The Office's liaison function is central to Agency efforts to integrate PVOs into USAID's strategic planning processes, and its sustained involvement in USAID policy development will help Bureau efforts to achieve this objective.
In addition to the direct contributions PVC's SO makes to Bureau-level SOs 3 and 5, the Office plays a small role in the Bureau's effort to achieve BHR SO 4, through its Farmer-to-Farmer program and Cooperative Development Grant program, both of which focus on increasing agricultural production and ultimately improving household nutrition.

Overseas, PVC requires that the programs of its recipients fit

clearly into Mission strategies and facilitate the achievement of Mission-level SOs and Goals. In developing their proposals in response to PVC RFAs, U.S. PVOs often consult with USAID Missions in the countries in which they intend to work. Missions and Regional Bureaus are also involved a process that links PVO programs to USAID objectives when they review proposals developed in response to PVC RFAs. While this document is not the proper vehicle for examining the range of Mission-level objectives to which the programs of PVC grantees respond, it is important to note that such integration is a PVC objective, and the Office includes within its Strategic Plan several steps that focus on improvements in the integration of Mission and PVO objectives at the country level.

B.Strategic Objective and Intermediate Results

1.Strategic Objective: Increased Capability of PVC's PVO Partners to Achieve Sustainable Service Delivery

PVC's Strategic Objective (SO): increased capability of PVC's PVO partners to achieve sustainable service delivery reflects two main themes that are evident in PVC's portfolio: institutional strengthening and service delivery. At this level, the capability on which PVC's efforts focus is the collective capability of the U.S. PVO community and the ability of this community to bring about sustainable service delivery overseas, whether through its own efforts or through the work of its local NGO partners.

PVC's articulation of its SO stresses the importance of capacity development and the essential fact that increased capacity must, if it is to be justified, lead to results, in terms of goods and services delivered at the community level. A capability at the level of the U.S. PVO community depends not only on the IRs PVC has included in its Results Framework, but also on the effectiveness of PVC and USAID Mission efforts to integrate PVOs' efforts into Mission strategies at the country level. Extensive and varied field experience is essential for the full development of the U.S. PVO community's capacity to ensure sustainable service delivery overseas.

The fundamental problem that PVC's strategy, and its SO in particular, is designed to alleviate is that of the institutional limitations of U.S. PVOs, and their local partners, to deliver services on a sustainable basis. The causes of problems PVOs and CDOs face in this regard are both internal and external to the entities PVC assists. The internal causes of sub-optimal institutional capacity are related to the natural growth curve and maturation of non-profit organizations. Some newer PVOs lack sufficient sophistication, in terms of their human resources, equipment and management systems, to deliver services effectively and in a manner that can be sustained in the countries in which USAID works. Other PVC-assisted PVOs, in contrast, have become quite sophisticated over the years, as a result of capacity building grants they received. Yet even these more sophisticated

PVOs face
problems of an external, and often budgetary, nature which can impede their ability to ensure sustainable service delivery.

Work already carried out by PVC has shown notable success in strengthening the PVO community. For example:

■PVC Matching Grant support has resulted in the creation of professional microenterprise units in eight PVOs that are sustaining vastly increased numbers of small loans.

■Through Child Survival Grants, more than 25 PVOs have developed technically rigorous child survival programs that both deliver effective services and transfer skills to local health providers and local organizations.

■Implementation capacity for the Farmer-to-Farmer Program has increased from an initial set of two grantees in 1990 to six at the present time, and it is expected that still more grantees will be added in 1997. This program is a proving ground for developing professional international volunteer assistance programs and the management systems required to support them.

■Under the Cooperative Development Program, major U.S. cooperatives have developed an international capability to promote and assist counterpart cooperatives and cooperative federations in third countries. Three new grantees were added to the program in 1995 to expand the sectors in which U.S. cooperatives have international expertise.

■The Ocean Freight Reimbursement Program (OFR) enables PVOs to expand their level of operations to areas where they normally would not be engaged due to prohibitively high shipping costs. The program allows smaller organizations as well as large established groups to expand their operational capacities. Because smaller organizations tend to rely on volunteers to carry out their OFR activities, the OFR program indirectly contributes to expanding the size of the volunteer base for development assistance.

■As of the end of March 1996, the Denton Program, which helps to ensure that medical supplies and equipment reach programs in developing countries for the lowest possible cost, had received 102 applications from 63 organizations requesting transport of 5,542,658 lbs. of humanitarian aid.

■Development Education is a program USAID established to facilitate widespread public discussion, analysis, and review of the issues raised by the 1980 Presidential Commission on World Hunger and its call for increased public awareness of the political, economic, technical and social factors relating to hunger and poverty. The program makes grants and provides capacity building services to PVOs through an annual conference on education

and outreach methodologies and through the dissemination of best practices utilized in the PVO community. All Development Education projects have the potential to interest and involve the U.S. public in development issues.

PVC has a number of grant programs that will contribute to the achievement of this SO. In addition, PVC views the work of its staff on policy development, liaison with USAID Missions and Regional Bureaus, the communication of “best practices” to members of its partner community, and its efforts to disseminate information on PVO programs to the public as substantive contributions to the achievement of this SO.

To the degree possible in USAID’s current budget environment, PVC will identify and use opportunities for cost savings in some areas to support the introduction of more innovative approaches in others.

2.Intermediate Results

The five Intermediate Results (IRs) outlined in this section are all expected to contribute to the achievement of PVC’s SO. They do so in a manner that cuts across Office units. Specific IRs are not associated with one particular division or grant program. Instead, elements of the work carried out in each of PVC’s divisions contribute to several of these objectives. The result of PVC’s decision to go forward with cross-cutting IRs has been an improved understanding on the part of each of its divisions of the parallel and complementary work of other divisions. From an implementation perspective, these cross-cutting IRs require closer coordination between divisions, as well as encouraging a sense of shared responsibilities for managing progress towards and ultimately achieving PVC's IRs.

In developing its Results Framework, PVC staff and partners examined the causal links in the PVC strategy below the IR level. Objective Trees were developed that identified lower level results, activities which PVC is currently carrying out in support of those results, and additional activities which PVC may elect to undertake in the future. These Objective Trees were discussed and refined in a day-long strategic planning exercise in which all PVC staff were involved. Figure 1 on page 19 displays PVC's Goal, Sub-Goal, SO and the five IRs that support this structure of results. The most important lower level results identified through this process are shown in Figure 2 through Figure 6 which identify subordinate results that contribute to each of the Office's five IRs. The causal relationships within each of these supplementary Objective Trees is described below, as PVC’s IRs are taken up in sequence.

IR 1:Operational & Technical Capacity of U.S. PVOs Improved

(1)Rationale and Linkage to PVC’s Strategic Objective

In contrast to PVC’s SO, which focuses on the collective capability of U.S. PVOs to bring about sustainable service delivery in developing countries, IR 1, depicted in Figure 2 below focuses on the operational and technical capacity of individual PVOs. More specifically, it focuses on the operational and technical capacities of PVC grantees.

The operational and technical capacity of U.S. PVOs directly affects their ability to achieve sustainable service delivery. Capacity, in this sense, describes both the extent and limits of PVO ability to carry out the kinds of tasks that are necessary to ensure sustainable service delivery, including training and technical assistance provided to NGOs.

(2)Subordinate Results and Strategy

Improvements in the operational and technical capacity of PVC's grantees are viewed as resulting from changes in PVO staff capacity and changes in their internal planning and administrative systems. These two areas comprise the key subordinate results upon which improvements in capacity at the level of IR 1 depend. Invariably, any decision about how to display the subordinate results that lead to the achievement of an IR ignore some important linkages. In the case of IR 1, the division made by Figure 2 between staff and system improvements could suggest that these areas of action can be addressed independently. Such is not the case, however. Planning and administrative systems in U.S. PVOs affect staff performance, and system improvements depend upon staff action. To understand PVC’s strategy for IR 1, the existence of these kinds of linkages must be recognized.

IR 1.1Staff Capability Strengthened

Staff capability is defined here as a combination of skills, knowledge and access to resources. Basic skills are a core asset of an organization. They are embedded in the educational credentials and previous work experience of staff. To these core skills staff continually add new knowledge. This includes knowledge about the sectors and countries in which the PVO operates and about the experiences of other PVOs.

a.Ensuring that Appropriate Skills Are Available

In order to improve the quality and extensiveness of their work, PVOs often need to have access to specialized skills. Sometimes those skills exist within the organization, but are unavailable because there are many competing demands for individuals who have those skills. PVOs that simply need more skilled individuals can find themselves just as constrained as those that need skills that

no one in the organization possesses. PVOs gain access to the additional skills they need either by hiring new staff or by accessing qualified external resource personnel on a short term basis.

PVC grants, particularly its Matching Grants and its Child Survival Grants, offer PVOs an opportunity to upgrade their staff skills, either by hiring new personnel or engaging experts on a short term basis. In the Child Survival program, for example, grantees are required to have technically qualified personnel who are knowledgeable about state-of-the-art practices.

b. Applying Best Practices

In order to perform optimally, the staff of U.S. PVOs need to be alert to new information and practices that can improve the operation of their programs and increase the likelihood of sustainable service delivery in developing countries. What is needed is an ongoing set of processes that brings new information to the attention of busy staff.

Staff initiative is one of the resources upon which PVOs depend to ensure that “best practices” in their fields of endeavor are known and applied. Requirements rarely encourage people to search out information or to read and absorb it. Rewards for doing so, including recognition, are far more likely to spur these kinds of efforts. A second mechanism for bringing new information, particularly information about management practices within the organization, to the attention of staff is training. In addition, the identification and application of best practices depends upon improvements that U.S. PVOs make in work planning and in their monitoring and evaluation systems.

PVC support for efforts by the staff of U.S. PVOs to gain knowledge about the state-of-the-art in the fields in which they work and to acquire “lessons learned” from USAID’s experience with a wide range of programs and countries comes from a number of sources. Involvement in PVC’s grant programs provides PVOs with a strong line of access to information from USAID sources. For example, PVC’s Matching Grants Program has in place a support program to enhance the capabilities of its grantees called Global Excellence in Management (GEM). Through GEM, a series of conferences and seminars are conducted throughout the year to strengthen staff capabilities and improve planning and administrative systems. GEM support activities include the Organizational Excellence Program and Executive Certificate Program to strengthen strategic planning and leadership capabilities of PVO and NGO staff; the PVO and NGO Partnership Program; and the Sector Organizational Alliance Program, all of which focus on improved collaboration; information-sharing and networking; and a Global Bench-Marking initiative focused on sharing information about best practices in a range of technical sectors in development.

The Matching Grants program also continues to evolve as the state-of-the-art for sustainable service delivery deepens and broadens in

scope and focus. Through direct grant support for programs collaboratively designed by PVOs and USAID Missions, local cost recovery models have emerged. Support to hire well-qualified technical staff for Save the Children, Catholic Relief Services, Foundation for International Community Assistance, Inc., and Childreach microenterprise programs, for example, has resulted in the development of coherent and acceptable microenterprise development program methodologies where efficiency and scale are paramount and are leading towards self-sufficient local programs. In the first instance, it is important for U.S. PVOs to ensure that best practices are shared internally and applied to future programming within the organization that identified these improvements. Several other PVC efforts also provide opportunities for the exchange of information on "best practices" between organizations, including:

■Under PVC's Child Survival Grant program, a technical support contract was established which focuses on the identification and dissemination of best practices and state-of-the-art knowledge to PVC funded PVOs. This type of activity is also undertaken in support of PVC's Development Education Grants.

■The Small Enterprise Education and Promotion Network (SEEP), created through minor support to its Secretariat under the Matching Grant Program, provides a venue for PVOs implementing credit and savings activities to learn from each other and from experts in the field of microenterprise lending.

■The recently initiated Sustainable Services Delivery Program (SDS) is a technical assistance vehicle designed to assist growing numbers of PVOs to design and implement sustainable service delivery, particularly those organizations that combine a poverty lending component with education and training models.

■To transfer state-of-the-art knowledge in the Farmer-to-Farmer Program (FTF), grantees assign highly qualified volunteers, who are current in their professional knowledge and experience in the U.S. agricultural sector, to assist host organizations in developing, middle income and emerging democracy countries.

■Through its annual conference for Development Education program grantees, PVC exchanges information on best practices as well as recent information on education and outreach methodologies.

In addition to ongoing work that focuses on the transfer of state-of-the-art knowledge and on the awareness of PVO staff of "lessons learned" through USAID's experience overseas, PVOs are encouraged to use resources under their PVC grants to ensure that staff are given adequate training when new management systems, of the type discussed under IR 1.2 below, are introduced. PVC also works with grantees to ensure that they have an adequate understanding of PVC's requirements. While this work has a "hands-on" quality, it properly falls within the realm of PVO management training. For

example:

■Under the Child Survival Grants and Development Education Grants programs, PVC provides consultations and written feedback on proposals, implementation plans and work plans in order to improve implementation systems.

■To assist new PVOs, PVC's staff hold de-briefings with those PVOs whose Matching Grant proposals were judged non-competitive. These meetings often address the PVOs' strategic planning processes, workplans, business plans, and field backstopping in relation to the proposed activity. Taking these considerations into account, a PVO may then strengthen and revise its proposal for future submission.

■As a means of familiarizing PVOs with USAID's approach to strategic planning and performance measurement, PVC ran participatory workshops this past year, in conjunction with its briefings for the PVO community on PVC's new RFA procedures.

IR 1.2Improved Planning and Administrative Systems Utilized

This subordinate IR focuses on the quality of PVO planning and administrative systems. Generally speaking, grantees with which PVC has worked over an extended period tend to have stronger planning and administrative systems than do newer PVOs or PVOs that have not worked with USAID in the past. The upgrading of planning and administrative systems is a complex task for any organization. For PVOs that operate with a minimal administrative staff, it can be difficult to find the time and the resources required to address needs in these areas. For this reason, PVC encourages and funds such improvements through its grant programs.

PVC's grant programs support efforts that its PVO grantees are making to upgrade their planning and administrative systems, as described below:

a. Planning and Performance Monitoring Systems

PVC's Matching Grant Program specifically encourages the adoption and utilization of strategic planning approaches and systems. In addition, aspects of both the GEM and SDS efforts focus on improvements in PVO strategic planning systems. Improvements in the implementation and work planning processes in PVOs are encouraged by PVC. Matching Grant and Child Survival Grantees are required to develop detailed implementation plans within nine months of the time they receive their grants. These plans are submitted to USAID for review and comment. They are a vehicle for strengthening PVO technical and implementation capacity. Informal technical assistance is also provided to PVC grantees by the PVC staff.

PVC holds workshops with its grantees to assist them with

monitoring and evaluation systems; to help them standardize the methods they use to ascertain what is needed in a particular situation; and to collect performance data on their efforts. Workshop sessions that focus on survey methodology address needs in this area. In the Child Survival Program, such skills are particularly important since all Child Survival Program grantees are required to complete baseline and final surveys in order to measure impact of the proposed program(s). Historically, all of the grant programs PVC administers on a competitive basis have included requirements for mid-term and final evaluations, as part of institutional strengthening. PVC has worked collaboratively with grantees to set up these evaluations. Evaluation teams normally included staff of the PVO

involved as well as external evaluation professionals who assessed program achievements and helped to strengthen PVO in-house capability to conduct evaluations and use evaluation findings to improve program content.

b.Administrative Systems

Participation in PVC grant programs requires a high level of rigor on the part of PVOs. Grantees in the Matching Grant program and PVOs that participate in the Ocean Freight Reimbursement, for example, must meet guidelines established in PVC RFAs for financial management and procurement. To this end, PVC provides periodic workshops, alone or jointly with other bureaus, which PVO grantees and new applicants are encouraged to attend.

Through its grant programs, PVC encourages PVOs to strengthen staff capabilities in field support. Field support is a headquarters function through which backstopping is provided to personnel overseas. Salary and insurance payments, telecommunications support and assistance in establishing and supplying an office may be involved. In addition, field support may involve providing short-term consultants, conducting site visits, and supporting field staff through training. Headquarters offices must effectively respond to requests from the field and ensure that lessons from field experiences are incorporated into its planning and management systems, thereby making sure that lessons learned are accessible organization-wide and are applied to future programming. PVC's support allows U.S. PVOs to expand and upgrade their staff in order to improve their organization's performance of this function. Improvements in the physical capital of an organization can also help to enhance its planning and administrative systems. PVC grants also provide PVOs with a basis for upgrading and introducing computers, fax machines, computer software and Internet access where they were not previously available.

IR 2:Strengthened Partnership Between USAID and U.S. PVOs

(1)Rationale and Linkage to PVC’s Strategic Objective

Strengthened partnerships between USAID and U.S. PVOs (IR 2) are central to PVC's efforts of realizing its strategic objective of increasing the capabilities of PVO partners to achieve sustainable service delivery. PVC's grant programs and related activities enable it to engage in dialogue with senior management of U.S. PVOs on policy and programmatic issues of importance to PVC and its PVO partners. Such collaboration also indirectly contributes to strengthening the local partners of U.S. PVOs which, in turn, helps to advance USAID's broad strategic development objectives. In addition, strengthened linkages between USAID and PVOs also enhance the overall capabilities of the Office to address the concerns and interests of the beneficiary groups that PVC supported development programs are designed to help. Similarly, by joining with the PVO community to work on development issues of mutual concern, PVC is better positioned to advance the Agency's New Partnerships Initiative (NPI) which focuses, in part, on the linkages between U.S. PVOs and local NGOs. Moreover, through our relationships with the PVO community, the Office is drawn into the mainstream of development initiatives dealing with primary health care, environmental protection, small business development, the expansion of opportunities for women to participate in and benefit from the development process and democratic initiatives.

Exemplified by shared goals, trust, and reliance upon the strengths of each partner, a healthy partnership provides the underpinning for progress toward sustainable development. If the partnership is truly successful, both USAID and U.S. PVOs will achieve development results that neither could alone. PVC’s efforts to facilitate a strong and broad-based partnership will help to ensure that the U.S. PVOs with which it works are acting in concert with USAID goals, are results-oriented, and are able to accomplish lasting change. For example, the strengthened partnership toward which we strive will be reflected in improved PVO programs that match USAID programming priorities and utilize approaches that include greater host country participation in program design and implementation; feature partnership relationships with indigenous NGOs; and promote the development of civil society through private organizations. As the partnership itself grows stronger, so also will the programs that are built upon it.

(2)Subordinate Results and Strategy

A strengthened partnership between USAID and the U.S. PVO community is an essential element of PVC’s overall strategy. At the same time, some of its elements are beyond PVC’s direct control. In these areas, PVC must use its influence to bring about change, rather than its resources. A similar situation pertains when USAID Missions prepare Results Frameworks that incorporate the tasks that other donors are expected to carry out.

PVC views the development of a strengthened partnership between USAID and the U.S. PVO community as dependent upon three subordinate results, including:

■The maintenance of a supportive policy framework (IR 2.1);

■An enhanced dialogue between U.S. PVOs and USAID (IR 2.2); and

■PVC’s Promotion of PVO Strengths and Comparative Advantages as a USAID Implementing Agents (IR 2.3).

Figure 3 on the following page illustrates this relationship.

IR 2.1 Policy Framework Maintained

Broadly speaking, the kind of policy framework that is needed to facilitate a strengthened USAID partnership with the U.S. PVO community already exists. The task that remains is to maintain and build upon this foundation.

Improvements in the policy framework for a strengthened partnership with the U.S. PVO community have been made over the past several years, with the encouragement of USAID’s Administrator. USAID’s PVO Partnership Policy Paper and the NPI are critical elements of this framework. The work of the Advisory Committee on Voluntary Foreign Aid (ACVFA) is also essential to the maintenance of a sound policy framework in this area. In addition, ongoing efforts by PVC to simplify its PVO registration procedures and other paperwork processes are helping to create a more collaborative atmosphere. So too are the efforts PVC has made to develop clearer and simpler RFA guidelines, and to explain them in workshops for the PVO community. USAID’s Customer Service Plan, which began with a survey of PVC’s PVO partner-customers, has already been helpful in identifying ways in which the partnership sought by this IR can be encouraged.

USAID’s partnership with the PVO community is strengthened when USAID policies affecting PVOs reflect PVOs' views and comparative advantages. PVC helps to facilitate the inclusion of PVOs into Agency policy-making. Specific examples include:

■PVC's involvement in the development of the New Partnerships Initiative, on which PVO views were actively sought as the initiative evolved;

■Office involvement in the development of USAID's new PVO Policy Paper, and its role as a representative of PVOs' views;

■PVC involvement in the revision of USAID procurement guidelines, which benefitted from issues and observations offered by PVOs; and,

■ACVFA quarterly meetings and its preparatory Subcommittee meetings

where major policies are considered, and recommendations are provided to USAID after being discussed in the public quarterly meeting forum. In addition to providing input on issues such as procurement and travel policy, ACVFA recently provided USAID with recommendations on Agency policies and directives dealing with women in development.

IR 2.2 Dialogue Between USAID and PVOs Enhanced

A dialogue of the type suggested here consists of information that flows in both directions. We are seeking to open and maintain lines of communication through which PVOs are informed about USAID policies, programs and procedures, and can contribute and respond to them. The two-way flow of information should also include evaluation findings and other sources of "lessons learned." Open communication allows both partners to understand the framework in which each operates, and this shared understanding helps to strengthen the partnership.

PVC initiates communication about program-specific information by issuing RFAs for PVC's major grant activities. These RFAs outline program guidelines and eligibility criteria, and provide details about the parameters of USAID assistance. PVC grantees are also provided parameters for their programs through clauses in cooperative agreements and in guidelines for preparation of detailed implementation plans. In addition, RFAs also inform and provide guidance to PVOs about ways in which they can, with PVC assistance, build institutional capacity in program areas of importance to USAID.

PVC also promotes two-way dialogue by hosting conferences and workshops. PVC conducts an annual RFA workshop which serves as a forum for communicating policy and program information. In addition, operational units conduct specific workshops such as the CDO seminar series, Farmer-to-Farmer Program Implementors' conferences, and PVC's Child Survival workshops.

Processes for program monitoring and evaluation exist within USAID and in a number of U.S.PVOs. Unfortunately, the Agency and its PVO partners do not necessarily share key lessons learned. Even more difficult to ensure is the exchange of lessons between one PVO and another. Our two-way communication focuses directly on this exchange to address gaps in this area.

To facilitate an exchange of information between USAID and the PVO community as well as among PVOs, PVC hosts annual conferences and workshops for PVOs that discuss program criteria and/or technical issues; provide a forum to share experiences and lessons learned; and provide information on "state-of-the-art" in various technical sectors. Specific examples include:

■Opportunities for exchanging lessons learned and information about best practices in the RFA workshops PVC conducts, including its

workshops for those PVOs that are involved in the Farmer-to-Farmer program in the NIS region;

■Quarterly meetings that involve USAID Bureaus and CDOs in discussions of topics of mutual interest, such as CDO participation in USAID's NPI initiative;

■Annual conferences for Child Survival grantees and for Development Education program collaborators which bring USAID and PVO staff together to share experiences, lessons learned, and best practices over a 2-3 day period; and,

■Small Enterprise Education and Promotion Network (SEEP) workshops that bring PVO practitioners together to discuss the latest developments in the microenterprise field. As a funder of SEEP, USAID representatives also frequently attend these sessions.

Finally, PVC strengthens the two-way dialogue between USAID and the PVO community by administering post-proposal review debriefings. PVC comments on PVO program concepts and provides detailed debriefings after grant proposals are reviewed. Other mechanisms used to help solidify the linkages between PVC and the PVO community include, but are not limited to: conducting evaluation debriefings; promoting PVO capabilities with other parts of USAID and outside the Agency; opening a PVC staff dialogue with USAID/Missions regarding PVO services; responding to Congressional inquiries about PVO activities and accomplishments; and hosting brown bag luncheons to spotlight particular PVO programs.

IR 2.3 PVC Promotes PVO Strengths and Comparative Advantages

In the view of PVC’s PVO partner-customers, one of PVC's important roles is that of advocate for PVO involvement in field programs with Missions and Bureaus. By being knowledgeable about PVO capacities and sharing that knowledge with other parts of the agency, PVC can open doors that might not otherwise be open to PVOs and the local NGOs with which they work. PVOs also need to perform to make this element of the IR # 2 structure effective. They must market themselves to Missions and seek opportunities to help Missions develop their strategies as well as pursuing opportunities to implement particular aspects of these country-level strategies.

A strengthened partnership is supported by PVC efforts to build an awareness and understanding of PVO strengths and comparative advantages by disseminating information including:

■Detailing PVO capabilities to other parts of the Agency and other donors;

■PVC staff dialogue with Mission staff while on TDYs;

■PVC staff serving on proposal review panels for other Offices,

particularly those that include submissions from PVOs;

■Responding to requests for information from other USAID units, Missions, Congress, and the general public;

■PVC staff hosting brown-bag luncheons highlighting particular PVO programs; and,

■Sharing evaluation lessons throughout the Agency.

IR 3:Strengthened U.S. PVO and NGO Partnership

IR 3 focuses on the relationships that link U.S. PVOs and local NGO partners overseas. The rationale for this IR and PVC's strategy for achieving it are outlined below.

(1)Rationale and Linkage to PVC's Strategic Objective

In several of PVC's grant programs and in Mission-funded efforts, U.S. PVOs are moving into a "mentoring" role, i.e., they are helping local NGOs to develop the capacity to provide sustainable service delivery on their own. This approach has the potential for multiplying the value of U.S. PVO activities several-fold. At best, any one U.S. PVO will reach only so many people when it delivers services directly. When it works

through and strengthens local NGOs, it may reach higher numbers of people.

IR 3 is critical for achieving increased capability of PVO partners to achieve sustainable service delivery because NGOs are themselves change and delivery agents. As USAID's policies make clear, efforts to strengthen local NGOs are valuable in and of themselves. One reason is that NGOs are an important element of the civil societies USAID is helping to build. That these NGOs can also deliver services which are important for other developmental reasons is an added benefit.

(2)Subordinate Results and Strategy

Figure 4 below presents the elements that work together for the achievement of IR 3. Each element of this strategy focuses on an important aspect of the relationship between U.S. PVOs and their overseas partners. As indicated above, empowerment is critical for a meaningful partnership. For this reason, IR 3.1 focuses on this aspect of the PVO-NGO relationship strengthening effort. IR 3.2 focuses on the modalities that U.S. PVOs and their local NGO partners utilize to solidify their working relationships and to deliver the services they both consider important. IR 3.3 looks beyond the one-to-one linkages that are being established between

PVOs and their NGO partners to the development of networks of organizations or associations that can provide support to the efforts being made by PVOs and NGOs.

IR 3.1 Empowerment of Local NGOs and other Local Partners of PVC Grantees

In order to have a strong partnership between U.S. PVOs and local NGOs, both participants must be empowered. The two-way communication and equal collaboration implied by partnership cannot be achieved without empowerment of NGOs. A key purpose of such partnerships is to strengthen the NGOs to be able to assume more responsibility to design and deliver development programs.

PVC views the empowerment of local NGOs and other local partners of U.S. PVOs as dependent upon the achievement of several lower level results, including: training provided to NGOs and other local partners by U.S. PVOs; technical assistance provided to NGOs and other local partners by U.S. PVOs; successful efforts by U.S. PVOs that facilitate the registration of local NGOs; and PVC promotion of the role of NGOs in USAID strategies.

Training of NGOs by U.S. PVOs includes direct training and training of trainers. Many of PVC's grant programs include both forms of training as essential elements of their field activities. Training can consist of technical competency or managerial, administrative and financial skill development. PVOs working with PVC also use various methods of providing technical assistance to their NGO partners. As with training, technical assistance enhances the NGO's managerial competence and technical capacity.

The registration of LPVOs supports the development of a sound enabling environment for NGO activity. It includes policy and operational guidance. By helping NGOs register in their country, U.S. PVOs enhance the NGOs ability to deliver services and achieve critical mass.

PVC is a focal point in USAID for disseminating information on best practices and lessons U.S. PVOs have learned about working with and through local NGOs. To accomplish this, PVC will focus its activities on: improving PVC's dialogue with the NPI Leading Edge Missions (LEMs), increased support to NGOs through PVC's U.S. PVO partners, and disseminating best practices and other relevant information on NGOs.

IR 3.2 Clearly Defined Partnerships and Other Collaborative Modalities Employed

PVC already promotes formalized relationships between PVOs and NGOs with those of its grantees who have programs that can move toward greater reliance on local NGOs to deliver relevant program

services. In practice, the development of such linkages is facilitated by the existence of collaborative modalities through which such partnerships can be strengthened. PVC grants represent one such modality, but they alone are not sufficient. Other vehicles for collaboration also need to be in place, e.g., links with and through other international donors, North-North PVO links, South-South NGO links, and North-South links and various resource transfer mechanisms.

PVC has developed links with other international donors which will be expanded in the future. These donors include: European Commission, European Union, World Bank, and other bilateral and multilateral agencies. It is PVC's intention to use these linkages to promote the use of PVOs and NGOs as implementors of development assistance programs wherever such organizations have a comparative advantage. PVC also has a set of programs that facilitate and nurture strengthened PVO-NGO partnerships, e.g., GEM, SEEP, SDS. These programs help to improve the quality of PVO programs and, by extension, the quality of programs run by the local partners of these PVOs.

IR 3.3 Local and Global Networks of PVOs and NGOs Strengthened

A critical element of the strengthened partnership is the construction of sustainable local and global networks which promote the generation of a critical mass of development information. This element focuses on the value of information for empowerment through mutual learning.

PVC has supported the creation of strong networks like SEEP. This network of PVOs engaged in microenterprise is also beginning to develop national level networks and affiliates at the regional level, particularly in Asia and West Africa. Through these networks development information can be shared. In addition, such networks can provide information relating to emerging NGO consortia, which are being encouraged by PVC. Progress in this area depends upon success with a lower level objective, namely, the improvement of information on NGO consortia.

Various PVC grant programs, including its Development Education program, support the expansion of electronic communication systems that link North-South and South-South partners within the PVO community. InterAction's creation of a "Home Page" on the Internet is but one innovation of this sort. PACT and other PVOs and consortia are developing other interactive connections. Networks such as SEEP allow for the dissemination of technical information and best practices, and are encouraged to do so by PVC. The technical support contract for PVC's Child Survival Grant Program has a newsletter that is also productive in this regard. Annual meetings of Child Survival and other grantee clusters also are particularly useful.

IR 4:Improved Mobilization of Resources by PVC's PVO Partners

(1)Rationale and Linkage to PVC’s Strategic Objective

In the current environment of shrinking resources within USAID, the PVO community must turn to other means of mobilizing financial and human resources in order to deliver sustainable services. Partnering with other international donors, NGOs, unity-based organizations (CBOs), host country governments, and individual beneficiaries is vital to the continuation of sustainable delivery of services. Without continued financial, material and human resources it would be impossible for PVC's PVO partners to achieve sustainable service delivery.

(2)Subordinate Results and Strategy

Through this IR, PVC seeks to help PVOs mobilize financial, material and human resources. Several elements are considered important to the achievement of this objective including:

■An increase in human resources for PVO headquarters and field activities;

■Where appropriate, the sharing of local resources, e.g., facilities, local staff, by two or more PVOs;

■USAID resources, other than those of PVC, identified and accessed by PVOs; and,

■Increased USAID intervention to improve access to other donor resources.

As Figure 5 below indicates, these elements cluster into two sides of PVC’s strategy for achieving IR 4. On one side are efforts to help PVO mobilize human resources (IR 4.1); on the other, financial and material resource mobilization is highlighted (IR 4.2).

IR 4.1 Increased Mobilization of Human Resources

The mobilization of human resources, including paid experts and volunteers, is an important aspect of any long term strategy. Without access to a sufficient number of people with the right skills, PVOs will falter in their efforts to deliver services and expand their partnerships with local NGOs and other entities.

PVC currently supports efforts of PVOs to improve their ability to mobilize human resources through:

■Seminars, workshops, and other training, e.g., PVO Week, Proposal

Workshops, and GEM; and

■Structuring future RFAs to encourage collaboration with other institutions and partners, e.g., utilization of technical personnel at all professional levels for development activities on a reduced fee or voluntary basis.

IR 4.2 Improved Leveraging of Financial and Material Resources by PVOs

To ensure the expansion and long term survival of their programs in the absence of USAID funding, PVOs must diversify their funding sources. A portion of all grants provided by PVC should be used to leverage funding and to encourage PVC's grantees to increase fund raising activities.

PVC work that currently supports this subordinate result includes:

■Providing assistance to PVOs in identifying non-PVC sources of funding in USAID/W, USAID Missions, host governments and other donors. In the case of CDOs, existing requirements have been expanded to include contributions from their membership.

■Requiring PVOs to provide a 50 percent cash match for Matching Grants; providing subsidies (OFR) and supplemental free transport of goods and materials under the Denton Amendment; and requiring a 25% match in cash or in-kind contributions for other grant programs.

■Requiring, in some PVC programs, that PVOs partner with NGOs or host country governments. Many projects are partially funded by NGOs or host country governments as a result of this requirement.

■Requiring, in some PVC programs, that PVOs develop, and document in their initial funding proposals, plans for sustaining projects after PVC funding ends. PVC also encourages the exchange of information between PVOs on sustainability. This encourages and supports PVOs to mobilize resources from sources other than PVC.

IR 5:U.S. Public Awareness Raised

IR 5 focuses broadly on public awareness of to U.S. foreign assistance and the role that PVOs and NGOs play in delivering important development services. PVC’s development education strategy and its relationship to the Office’s SO are described below.

(1)Rationale and Linkage to PVC’s Strategic Objective

PVOs and CDOs are directly linked to the U.S. public. The importance of this linkage is underscored in Congressional intent with regard to the "privateness" criteria for direct funding to PVO and cooperative development grants programs, as well as in such

Administration language as that pertaining to the NPI. PVOs and Cooperatives require direct public support in order to continue providing their services. The U.S. Government's ability to support PVO and CDO projects is also dependent on public support.

Notwithstanding these linkages, foreign assistance does not enjoy significant or widespread commitment from the public nor, at present, from the U.S. Congress. PVC views this relatively low commitment as due to a lack of information, or sometimes to misleading information. The Office's strategy in this area is based on the assumption that, if the public were better informed and educated about the benefits of foreign assistance to developing countries and to the United States, public commitment and support would increase.

PVC also posits that its efforts to "raise public awareness" should capitalize on PVO and CDO self-interest: these organizations need increased public support and commitment (financial and political), and therefore ought to be predisposed to work more proactively to inform and educate the public -- particularly if they are given more encouragement and assistance from PVC. Members of the public that systematically can be reached by PVC grantees include not only the target audiences addressed by Biden-Pell programs but also the many individuals who make contributions to U.S. PVOs or who, for other reasons, seek or are receptive to information about PVO activities. Thus, IR 5 should be viewed as complementary to both IR 2 "strengthened partnerships between USAID and U.S. PVOs" and IR 4 "financial resources mobilized."

PVC is attempting to increase public awareness through educational efforts of grantees in its various programs, not just the Development Education program. PVC will begin working with all grantees to identify opportunities for public outreach and education related to PVC-funded activities. Lessons learned in these outreach and education efforts should be well documented. During 1995, PVC actively engaged the staff of USAID's Office of Procurement (OP) and its Legislative and Public Affairs Bureau (LPA) to ensure that its RFA language was appropriate both with regard to procurement policies and with broader USAID goals for improving public understanding of foreign assistance. PVC will draw upon this recent experience as it continues to build more understanding by, and cooperation with, other USAID offices regarding outreach and education by PVC-funded PVOs and CDOs.

(2)Subordinate Results and Activities

PVC's efforts to raise public awareness to the achievement of sustainable development in developing countries and emerging democracies approach the issue from an educational perspective. USAID cannot, by law, engage in lobbying on behalf of itself or the programs it administers, nor can its grantees. Conceptually, this poses a dilemma. The U.S. public needs to be informed about the

foreign assistance program, but not solicited. Recognizing this dilemma, the U.S. Congress has made a distinction between public education and lobbying that is both appropriate and useful. PVC's Biden-Pell Grant Program is a direct illustration and application of this distinction (see Section 5.2 below). In line with these principles, all of PVC's efforts to improve public awareness of the importance of sustainable development overseas apply development education approaches that fulfill the spirit as well as the letter of the law in this area.

With this framework in mind, PVC's strategy for achieving IR 5 relies on four subordinate results, which focus, in turn, on:

■The improved dissemination of information on development successes (IR 5.1);

■Improved public education about U.S. Government and PVO international development programs (IR 5.2);

■Improved information sharing about the importance of international affairs and "globalization" to the U.S. (IR 5.3); and,

■Stronger connections between PVOs and U.S. audiences (IR 5.4).

Figure 6 on the following page illustrates these relationships.

IR 5.1Improved Dissemination of Information on Development Successes

Public support for development assistance programs will be raised more readily if information on development successes is disseminated. Dissemination, in turn, presumes that USAID has successfully identified and documented these successes, as suggested in Figure 6. PVC efforts to gather and document information on program successes include interactions with other U.S. government entities who play a role in these programs, such as the U.S. Department of Agriculture. Documents that result from efforts to capture USAID's successful experiences are disseminated widely. Recipients include PVOs, USAID Missions,

the U.S. Congress, and universities and libraries around the United States. While PVC is prepared to accept the responsibility for ensuring that development successes which emerge from its grant programs are documented and disseminated, other operating units within USAID, including CDIE, also need to carry a portion of this burden.

IR 5.2Improved Education about U.S. Government International Development Programs

PVC reaches out with information on the grant programs it runs, as well as on other activities in which the Agency is involved,

through a variety of methods. As a first step, PVC supports the Agency's legislative and public affairs efforts, and PVC staff accept speaking and media engagements which highlight programs the Office administers. In addition, the Office reaches out to the public through its grant programs. Biden-Pell Grants are given for the specific purpose of providing public education with respect to international development and the work of the U.S. foreign assistance program. PVC's grant programs also serve an educational function when they make the work of the U.S. foreign assistance program known to U.S. PVOs that are new to international work.

Through its grantees, PVC reaches out to the communities from which these grantees draw their volunteers and resources. PVO and CDO representatives have numerous opportunities to help educate the American public. Farmer-to-Farmer Program volunteers who have returned from overseas assignments are particularly well-suited for this task. In addition, PVC considers ACVFA meetings and Quarterly Reports, as well as the annual VOLAG report the Office produces, important mechanisms for educating the public about the international development programs of the U.S. Government.

IR 5.3Improved Information Sharing about the Importance of International Affairs and “Globalization" to the U.S.

This IR is similar to IR 5.2 in that it deals with public education. Where it differs is in the nature of the message. Under IR 5.2, the messages with which PVC is concerned are largely programmatic -- what do USAID and the PVOs do overseas, how does their work help, and whom does it help. While it is extremely important to ensure that information of this sort is widely available, this information does not address questions about the value of foreign assistance and related international interactions, such as trade, at a general, or policy level. "Globalization", i.e., the increasingly dense networks of communications and trade that link the United States to other countries, is a topic that is much discussed, but not always well understood. This is particularly true for trade. It is important for the U.S. public to know, for example, that as countries develop, their imports from developed countries, including the United States rise, often as much or more than do their exports to these countries. As a result of economic development, U.S. sales to developing countries have risen dramatically over the last 40 years.

Through its grant programs, PVC assists with efforts that are being made not only by USAID, but also by the U.S. Department of Commerce, the U.S. Department of Agriculture and other agencies to bring together information that is pertinent to public discussions and policy making about foreign policy, foreign assistance and about such topics as "globalization." PVC also contributes to such efforts when its staff accepts speaking engagements and when it assists USAID's legislative and public affairs efforts to educate the public and provide the U.S. Congress with pertinent information on the programs USAID administers. Thus, for example, when lessons learned from child survival projects in West Africa are transferred

back to poorer sections of major cities in the United States through USAID's "lessons without borders" program, USAID contributes to the process of "globalization" in a positive way.

ACVFA meetings are another way in which PVC plays a role in raising awareness of issues that have policy implications. These meetings, like the annual conferences of PVC grantees, provide opportunities in which topics such as "globalization" can be explored collaboratively by PVOs and USAID staff.

IR 5.4 PVO Connections to U.S. Audiences Strengthened

Direct contact between the American public, PVO staff, Farmer-to-Farmer volunteers and others engaged in programs supported by PVC is strongly encouraged by the Office. This kind of "people-to-people" contact mirrors the practices and values these programs promote overseas. PVC also supports contacts through improved publications that flow from PVO and CDO programs as the institutional strengthening aspects of their grants begin to show results. Biden-Pell Grants are a powerful mechanism in this regard, since they reach so many Americans directly with information about the foreign assistance work of U.S. PVO community.

C.Critical Assumptions

In addition to assumptions that are inherent in PVC’s Results Framework and are discussed above for individual IRs, there are a number of critical assumptions that cut across PVC’s Results Framework. The first two assumptions focus directly on the operations of the Office and on USAID's commitment to greater involvement of the PVO community in USAID's development assistance strategy. These two assumptions have a direct bearing on PVC's ability to achieve its Strategic Objective.

Assumption:Even in the face of budget cuts and efforts to streamline Agency operations as part of its reengineering initiative, the need for a central point for PVO support and leadership of efforts that strengthen the USAID-PVO partnership will remain.

This assumption is fundamental to PVC's Strategic Plan and to the approaches it takes in efforts that not only will strengthen ties between USAID, the PVO community, and local NGO and other partners of these PVOs, but also will help to integrate the work of these entities with USAID's sustainable development agenda. As a central point for PVO support, PVC offers the Agency important opportunities for realizing management efficiencies when Missions must be closed. PVO and NGO programs that warrant continuation in countries where Missions are closing can, theoretically, be continued under PVC's grant programs. PVC already serves as a resource center on PVO and NGO activities for USAID as a whole, and will continue to do so. It also plays an important role in the eyes of USAID's PVO partners, serving as their gateway for

information and in some instances access to other parts of the Agency.

Assumption:USAID will increasingly utilize PVOs and NGOs to implement its programs. Investments in NGOs will continue to be seen as valuable because their existence and operations help to build the framework for civil society.

While PVC does not anticipate a reversal of USAID policies which would make this assumption untenable, the Agency's ability to follow through on its commitments to the PVO community requires monitoring, since USAID's actions to fulfill commitments, such as the proclamation made at the Social Summit to program 40 percent of USAID's development assistance resources through PVOs and NGOs, will also be monitored closely by the PVO community itself.

Three other assumptions also affect the ability of PVOs, in collaboration with PVC and USAID Missions, to achieve the Sub-Goal and Goal outlined in the Office's Results Framework.

Assumption:There will continue to be a vital role for U.S. PVOs and CDOs to play as “wholesalers” of technical assistance, training, and financial assistance for local NGOs.

This assumption focuses on the need for and perceived value of the kinds of assistance that U.S. PVOs can provide. Feedback from NGO partners of U.S. PVOs, host governments, and other donors about the need for and value of U.S. PVO assistance will be useful for monitoring this assumption. Care needs to be taken to ensure that PVO assistance to NGOs and other local organizations results in increased capacity rather than increased dependency. Some level of follow-up research may be necessary.

Assumption: Host governments and other donors will expand their commitments to working with and through PVOs and NGOs.

The validity of this assumption is essential for the financial sustainability of PVO programs, since non-U.S. Government and donor resources often serve as the basis for obtaining matching funds from private sources. Grant funds of this sort provide a “seal of approval” that PVOs can use in their efforts to mobilize resources. As PVOs continue to “scale-up” and replicate their programs and their operational approaches, government and donor support remains critical. To monitor the validity of this assumption over time, PVC will track the percentage of USAID funds going to PVOs as opposed to other types of implementors.

AssumptionAs PVOs become more experienced, there will be economies and efficiencies of scale within PVOs that will, in turn, yield development benefits.

In principle the existence of such economies of scale, and the efficiencies they enable, will lead to reductions in the cost of PVO service, on a unit cost basis. This assumption is an important

element of the proposition that PVOs and NGOs will reach ever increasing numbers of people with goods and services over time. In practice, such a concept is difficult to measure, because PVOs that focus on building capacity in NGOs rather than the direct delivery of services cannot organize their results and costs in a relevant set of "units." PVC will attempt to monitor it by periodically reviewing performance monitoring data and evaluation findings to determine whether larger, older PVOs appear to achieve the results they set forth to achieve on a more consistent basis than newer, smaller PVOs.

D.Commitment and Capacity of Partners to Participate in Achieving PVC's Strategic Objective

PVC intends to involve its PVO partners in all of the steps it takes to refine this plan, transform it into an implementation schedule, carry out activities, and monitor performance at the IR and SO level. Core and expanded teams, of the type assembled to help define PVC's Results Framework and related performance indicators, will be maintained, albeit with appropriate adjustments in focus and membership, throughout the period covered by this Strategic Plan.

Working together, PVC and its partners will assemble, review and interpret the data that PVC will need to prepare its annual Results Report and Resource Request. Where inconsistencies between expectations and actual performance appear, PVC will work with its partners to ascertain why, if possible, or to define terms of reference for a special analysis or evaluation if explanations remain illusive. Together, PVC and its partners will identify modifications in various modes of operation and activities that may be required if the IRs and SO presented in this Strategic Plan are to be achieved.

In planning its work with U.S. PVOs and their NGO partners, PVC is keenly aware of the fact that both of these groups are the Office's customers as well as its partners. Close interaction with these entities operationalizes USAID's reengineering guidance on customer involvement in an unusual way. It also has the potential to be highly productive. The value PVOs attach to the collaborative processes PVC established as this plan was developed was evident in their willingness to invest time and effort in the process.
PVC will work closely with its PVO partners to develop approaches and methods they and their NGO partners can use in collecting information on program performance. Information will be needed from the customers (beneficiaries) to whom PVOs and their NGO partners deliver services concerning their satisfaction with these services.

E.Sustainability

Sustainability is an important objective in PVC's Results Framework. U.S. PVOs and their local NGO partners are expected to focus their efforts on the establishment of service programs which

are sustainable over the long term, without continuous USAID support. To this end, PVC encourages its U.S. PVO partners to develop strategies and begin to demonstrate how they are increasing the non-USAID share of resources that support their programs and those of their local NGO partners.

To support increasingly sustainable programs at the level of individual PVOs and CDOs, PVC is placing an increasing emphasis on sustainability in its RFAs, particularly in the criteria it uses to review applications. PVC's Child Survival Grant Program recently established a policy limiting country-level programs to two funding cycles. In addition, PVC's Matching Grant program established a Sustainable Development Service (SDS) network to help its partners address sustainability challenges. As the network grows, PVOs and CDOs that have made progress in their efforts to achieve financial sustainability and build sustainability into their in-country programs will begin to serve as models by identifying and discussing best practices. Their experiences will help to teach those PVOs, CDOs and partner NGOs that are still struggling with these issues.

The partnerships that U.S. PVOs are establishing with local NGOs are themselves central to the sustainability of many PVO programs. Local partnerships extend the reach of U.S. PVOs while at the same time redefining their relationship to the development and humanitarian assistance process. By becoming mentors, they step away from the direct provision of services, while at the same time opening new doors. Partnerships with local NGOs will afford them with opportunities to move into new regions within countries, as well as into new sectors of activity.

F.How the Achievement of Strategic Objectives will be Judged

This section outlines the main performance indicators PVC is considering for monitoring its progress and judging its performance under this Strategic Plan. All of the performance indicators discussed in this section are tentative. Each must be further examined to determine not only whether it is feasible, but also what the cost and frequency of data collection would be.
With this caveat in mind, performance indicators are presented in this section at the level of the SO, as well as for PVC's Sub-Goal and each IR outlined in PVC’s Results Framework. While achievement and performance measurement at the Goal level is not solely the responsibility of PVC, the Office has identified some indicators at this level which it will look to USAID Missions and PVOs to monitor.

1.Performance Indicators at the Goal and Sub-Goal Level

At the Goal level, PVC anticipates that it will be able to use data collected by other USAID units to determine whether changes are occurring as a result of improvements in, or simply more extensive, service delivery by PVOs and NGOs. PVC would be interested in whatever data USAID or other international sources can make

available about, for example, changes in infant and child mortality rates.

At the Sub-Goal level, it is important for PVC to have a few measures of performance that are independent of the actions the Office supports to strengthen NGO partners of U.S. PVOs. The provision of assistance in this area is not sufficient proof that changes have actually occurred in NGO organizations. For this reason, PVC has identified several indicators that might offer independent evidence of improved capacity in local NGOs. It is the Office's intention to discuss these indicators further with its PVO partners and perhaps with several LEMs as well. Candidate indicators for further discussion at this level include:

■As a proxy for improved administrative and organizational capacity within local NGOs -- the number of NGOs that are registered as LPVOs with USAID could be counted;

■As a proxy for an improved ability to communicate among themselves and share best practices -- the percentage of USAID assisted countries where one or more formal associations of NGOs have come into existence could be counted;

■The percentage of LEM countries that have policies that encourage decentralization and participatory development approaches; the development of local NGOs, or partnerships with them; and

■The number of local NGOs that continue or expand their operations after assistance from a PVC grantee ends.

2.Performance Indicators at the Strategic Objective Level

Performance measures at the Strategic Objective level are essential for demonstrating that the end result of all of the activities that lead to and through Intermediate Results are achieved. Intermediate Results are necessary to achieve a Strategic Objective, but their existence, and the indicators thereof, do not prove that a Strategic Objective has been achieved. Indicators at the level of the Strategic Objective must be independent measures of accomplishment. In selecting performance indicators at the Strategic Objective level, PVC has also sought to measure the different dimensions of this objective statement, i.e., PVO capacity, service delivery, and sustainability.

Two capacity measures are included at this level:

■Change in the average score of PVC-supported PVOs on a PVC-developed capacity development “self-assessment” instrument;

■Change in the number of members of formal networks or associations of voluntary organizations.

The first of these is a rating system which allows PVOs to score themselves as they improve along several capacity dimensions that are defined by the instrument PVC has developed for this purpose. In addition, it is PVC's sense that PVO capacity grows as organizations learn from each other. A proxy measure of such learning, i.e., the involvement of PVOs in associations, was selected to capture this dimension of capacity expansion.

Service delivery measures are being examined by PVC and will be finalized in consultation with PVC's PVO partners. The following examples are illustrative. They are intended to measure service results which must logically be observable if sectoral improvements of the kind discussed at the Goal level are to occur.

■Changes in extent and quality of service delivery in key sectors in which USAID has invested through PVOs, e.g.:

--change in percentage of children immunized, using standard Agency definitions and approaches;

--change in volume of credit provided to microenterprises, or change in the number or percentage of microenterprises that receive credit.

PVC's selection of immunization and credit as initial measures of service delivery reflects not only the high proportion of its grants that support programs in these areas but also the quality of the measurement procedures used in these areas. The fact that data are already being collected on these indicators by other operating units in the Agency is important for PVC, since the Office will not engage in primary data collection at this level of its Results Framework.

Sustainability indicators are those which would lead PVC to believe that services initiated by PVOs and their NGO partners will continue after the initial grants that got them started have ended. Two indicators have been selected in this regard:

■Percentage of PVC supported PVO programs that are still providing services two years after PVC's support for these programs ends. At minimum, programs must sustain at least 50% of the service or coverage level achieved during the period of PVC support. For purpose of this measure, service delivery may be provided by a U.S. PVO or through its local partner;

■The percentage of PVO programs in which there is cost-recovery or cost-sharing at a level which is sufficient to indicate that local commitment or "ownership" exists.

Measures of the sustainability of programs are always difficult, since most are applicable only after USAID's involvement has ceased. Technically, this is the case for the first of the two indicators PVC will monitor in this regard. To gather data, PVC

will have to rely on its long term relationships with U.S. PVOs who will be in a better position to know whether programs with which they and PVC have been involved are sustained after PVC support ends.

The second indicator of sustainability PVC has selected is a "leading indicator", i.e., it is something that can be measured early on that has value as a predictor of future behavior. Local investments in the service delivery programs that PVOs and their local partners develop indicate that people in or close to the situation value the services that are being provided, and will continue to value them and support their delivery beyond the point where PVC's support for them ends.

PVC's ability to acquire useful data on the sustainability of the programs its grants support is not certain. Each of these measures requires further specification and consultation with PVC's PVO partners. What these indicators represent is a starting point.

3.Performance Indicators at the IR Level

At the IR level, PVC has identified several indicators for each of its five IRs. A number of the measures selected by PVC are experimental in the sense that the Office's ability to gather data in a systematic and cost-effective way has yet to be tested.

Indicators for IR 1 focus on whether the PVOs that receive assistance from PVC have improved their capacity in some observable way. In selecting indicators for this IR, PVC looked for conditions that would signal capacity improvements. The indicators PVC will examine in this regard include:

■Percentage of key U.S. PVO staff working on PVC supported grants who are technically qualified in the substantive field on which the grant program focuses, i.e., a Master's Degree or an equivalent level of practical, overseas experience in the program's substantive field;

■Average number of years that qualified technical staff (per the above) remain on the staff of the PVOs that receive PVC grants; and,

■Percentage of PVOs that have Strategic Plans in place.

The existence of qualified program staff and the ability of U.S. PVOs to retain these staff are viewed by PVC to be critical indicators of an improved operational and technical capacity in these organizations. Data on staff qualifications are already available from the PVOs supported by PVC. In operationalizing this indicator, PVC may ask PVOs to supplement and reformat information they already provide. As to targets for the first two of these indicators, PVC needs to work with the PVO community to ascertain the baseline situation and to identify a reasonable pace for

improvement, particularly with respect to the acquisition of technically qualified personnel.

System improvements are also essential for improved operational and technical capacity. The existence of Strategic Plans in grantee organizations is viewed by PVC as being a reasonable proxy indicator of an intention to improve an organization's operational and technical capacity to fulfill its mission. PVC would like to be able to determine whether the Strategic Plans that PVOs develop are actively utilized to guide their operations and to stimulate the systematic collection and analysis of performance data. Being realistic, however, it has initially limited its monitoring in this regard to ascertaining whether Strategic Plans are in place in its grantee organizations. While the baseline situation must be established before annual targets can be set, PVC anticipates that it will expect a significant proportion of its grantees to have well developed Strategic Plans in place by the end of the planning period. To acquire information on this indicator, PVC will begin to require information on PVO Strategic Plans as part of the annual grant reports.

For IR 2, PVC sought indicators that would demonstrate that interactions as well as the broad relationship between USAID and its PVO partners are improving. In any given year, one or two indicators might remain steady, but others would change, reflecting the vitality PVC is seeking in this relationship. The indicators PVC will examine for this purpose include:

■The percentage of recommendations presented by the ACVFA's Partnership Subcommittee that are adopted by USAID;

■The percentage of USAID program funds channeled through U.S. PVOs.

The first of these indicators was chosen because it demonstrates that open lines of communication exist which help to facilitate the USAID/PVO partnership, and that these lines of communication are both transparent and credible. PVC's decision to focus this indicator on recommendations of the ACVFA Partnership Subcommittee was made to ensure that all recommendations that counted toward this percentage are pertinent to what PVC is trying to measure, i.e., partnership. Information on this indicator is already routinely collected and monitored by PVC, thus the cost of using this indicator would be minimal. Prior to setting annual targets for this indicator, PVC will review the percentage of recommendations that USAID adopted in previous years. PVC will also consult with the ACVFA as it structures this indicator, i.e., it may be that recommendations of different kinds will need to be given different weights to reflect their complexity or implications for USAID operations.

The second indicator is one that USAID currently monitors and publicly reports. Only development assistance (DA) funds programmed by USAID are used to calculate this percentage. In

recent years, the percentage of DA funds channeled through U.S. PVOs was just above 25 percent. This percentage, which will be measured annually for the Agency by PPC, will be monitored by PVC as an IR 2 measure as well. Increases in the percentage would strongly confirm USAID's commitment to this partnership.

PVC's IR 3 focuses on an objective that is central not only to the Office's mission but also to the success of NPI. As in the case of the USAID-PVO partnership, PVC will examine indicators that show that PVO-NGO relationships are dynamic. Here again, some measures might remain steady over a couple of years, but in any given year, at least one measure should show positive movement.

■Percentage of PVC resources (monetary or in-kind, e.g., training, TA, etc.) transferred by PVC grantees to their NGO partners, as part of a cooperative agreement with PVC;

■Percentage of PVC grantees that have established formal partnerships or linkages with one or more NGOs; and,

■Percentage of PVC grantees and their NGO partners that are "on-line".

The three indicators selected for IR 3, when taken together, will draw a reasonably clear picture of both the nature and the extent of the partnerships that U.S. PVOs are developing with their local NGO partners. Resource transfers are a good measure of support for NGO development, but in the absence of formal linkages or frequent communications, they may not represent strong and stable partnerships. Conversely, communication without resource transfers may signify a relationship, but not necessarily one which will substantially strengthen the capabilities of a PVO's NGO partner.

Data on these indicators, while not currently available, can be established as an RFA requirement. PVOs know what resources they transfer to their local partners and should be able to estimate the dollar value of those transfers. Copies of formal agreements with NGO partners and e-mail addresses for these partners can also be solicited from the U.S. PVOs with which PVC works. Some information on e-mail addresses is already being collected. Targets for these indicators may need to be set arbitrarily at first, since no baseline data exists and there is no reliable way to collect data on undocumented resource transfers retrospectively. Working with its PVO partners, PVC will explore ideas such as increasing the percentage of resources transferred to NGOs by 15% over five years; doubling if not tripling the number of NGO partnerships characterized by a formal arrangement or agreements over five years, and an equivalent increase in the number of partnerships in which both partners are "on-line".

IR 4 is the building-block upon which sustainable service delivery at the SO level most depends. At this level, indicators were sought which show that PVOs are expanding both their range of

funding sources and the absolute levels that come from funders other than USAID. Indicators for this IR include:

■Median percentage of non-U.S. Government revenue of PVC grantees;

■Mean non-U.S. Government revenue of PVC grantees;

■Mean value of in-kind contributions to PVC grantees.

The first two indicators selected for this IR measure grantee success in mobilizing non-U.S. Government monetary resources, but they are distinct from each other in important ways. The first indicator assesses the dependency of PVC grantees on the U.S. government. Percentages will be determined for each grantee and then the median for all grantees will be calculated. The median of these percentages will be calculated instead of a mean because a median is not as susceptible to the influence of extreme highs and lows as is a mean. It is therefore a more reliable way of estimating the dependence of PVC grantees, as a group, on U.S. Government support. The percentages developed for individual PVC grantees will also give PVC a clear way of discerning which of its grantees would be most likely to benefit from assistance that focuses on resource mobilization strategies and techniques, i.e., the ones whose percentage of non-U.S. Government resources is below the median. The second of this pair of indicators will show how well PVC's grantees are doing as a group in raising funds from non-U.S. Government sources. The final indicator in this cluster enables PVOs to monitor and be credited for the degree to which their resource mobilization efforts lead to in-kind donations of goods and services, including volunteer time, that they would otherwise need to purchase in order to operate at their current and anticipated levels. PVC will use information supplied for the VOLAG report to arrive at current or baseline values with respect to each of these indicators. These baseline figures and any historical information that is available on past trends on these indicators will be used to establish a credible set of performance targets.

Indicators for IR 5 were perhaps the most difficult to define. Public awareness can at best be estimated; it is never known precisely. At the same time, there are behaviors that, if observed and recorded, provide indirect evidence of the public's knowledge and views. To assess changes in public awareness, PVC has selected two indicators which, over time, will provide indirect evidence concerning the achievement of this PVC IR.

■Percentage of Biden-Pell and other PVC grantees that measure changes in the knowledge/understanding of program target audiences as well as PVO contributors concerning the importance of sustainable overseas and the role that USAID and the U.S. PVO community play in achieving that goal. (PVOs will be encouraged by PVC to use replicable and clearly documented pre-and post-testing techniques to ascertain whether changes in awareness and knowledge

are occurring;

■Percentage of Biden-Pell and other PVC grantees that actively engage in efforts to record anecdotal and other qualitative evidence of changes in target audience and contributor awareness and understanding of foreign assistance. (While evidence of this sort is not as strong as that provided by more rigorous testing techniques, it too is important and may, for some PVOs, be a first step toward more systematic efforts to ensure that knowledge gained overseas about the results and value of foreign aid is being shared with people at home).

Both of these indicators are a measure of whether PVC grantees are themselves measuring program performance. Because of the wide variety of development education interventions funded through PVC's Biden-Pell grants, there is no reasonable way to systematize the measurement systems that grantees use to ascertain whether target audience knowledge of sustainable development has improved. What can be assessed, however, is the degree to which grantees engage in performance measurement activity, and the nature and quality of the performance measurement systems they put in place. In operationalizing this indicator, and setting targets in relation to it, PVC will work with its grantees to develop baseline data and establish reasonable performance targets.

Improvements in public awareness and knowledge of the importance of sustainable development overseas and the role that USAID and the U.S. PVO community play in contributing to the achievement of that goal are not an end in themselves. As indicated in earlier sections of this plan, PVC views improved public awareness and knowledge about foreign assistance as contributing to an overall improvement in public opinion concerning foreign assistance as well as leading to stronger commitment to and support for the international development goals of the U.S. government and individual PVOs. For this reason, PVC will also monitor one indicator of U.S. public commitment in this area. While PVC's work alone might not be sufficient to bring about positive changes at this level, evidence of a deterioration in public support for foreign assistance would certainly warrant PVC's attention. The indicator PVC will monitor in this regard is:

■Percentage change in public knowledge of sustainable development as indicated by national polling data, i.e., two questions for which time series data is being collected by Chicago Council on Foreign Relations:

--Those who favor giving economic aid to other nations;

--Those who favor a cutback on economic aid programs.

This indicator relies on data that has already been collected at least twice and on which PVC anticipates additional data will be collected without USAID funds. The study in which these data are

found is the Chicago Council on Foreign Relations volume on American Public Opinion and U.S. Foreign Policy, edited by John E. Rielly, which was published in 1991 and again in 1995. In 1991 and again in 1994, this study showed that 50% of the U.S. public favored giving economic aid to other nations. PVC's target for the planning period is the maintenance of at least this level of support for foreign economic assistance. As to the second polling question, data from 1991 showed that 64% of the U.S. public favored cutting back on foreign economic aid. In 1994, this percentage dropped to 62%. GLOSSARY OF TERMS

ACVFA Advisory Committee on Voluntary Foreign Aid
AID/W United States Agency for International Development/Washington
BHR Bureau for Humanitarian Response
CBO Community Based Organization
CDIE Center for Development Information and Evaluation
CDO Cooperative Development Organization
COOP Cooperative
DEVED Development Education
FTF Farmer to Farmer
GEM Global Excellence in Management
GHAI Greater Horn of Africa Initiative
IR Intermediate Result
JHU Johns Hopkins University
LEM Leading Edge Mission
LPA Office of Legislative and Public Affairs
LPVOLocal Private Voluntary Organization
NGO Non-governmental Organization
NISNewly Independent States (of the former Soviet Union)
NPI New Partnerships Initiative
OFR Ocean Freight Reimbursement
OP Office of Procurement
ORF Office Results Framework
PPC Program and Policy Coordination
PTA Parents and Teachers Association
PVC Office of Private and Voluntary Cooperation
PVO Private Voluntary Organization
R4Results Review and Resource Request
RFA Request for Application
SDS Sustainable Services Delivery Program
SEEP Small Enterprise Education and Promotion Network
SIDSociety for International Development
SO Strategic Objective
TA Technical Assistance
TDY Temporary Duty Overseas
USAIDUnited States Agency for International Development
VOLAG Report of American Voluntary Agencies Engaged in Overseas Relief and Development Registered with the U.S. Agency for International Development

U.S. Agency for International Development

CERTIFICATIONS, ASSURANCES, AND OTHER STATEMENTS OF APPLICANT/GRANTEE

1.ASSURANCE OF COMPLIANCE WITH LAWS AND REGULATIONS GOVERNING NON-DISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS

(a)The applicant/grantee hereby assures that no person in the United States shall, on the bases set forth below, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under, any program or activity receiving financial assistance from USAID, and that with respect to the grant for which application is being made, it will comply with the requirements of:

(1)Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352, 42 U.S.C. 2000-d), which prohibits discrimination on the basis of race, color or national origin, in programs and activities receiving Federal financial assistance;

(2)Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), which prohibits discrimination on the basis of handicap in programs and activities receiving Federal financial assistance;

(3)The Age Discrimination Act of 1975, as amended (Pub. L. 95-478), which prohibits discrimination based on age in the delivery of services and benefits supported with Federal funds;

(4)Title IX of the Education Amendments of 1972 (20 U.S.C. 1681, et seq.), which prohibits discrimination on the basis of sex in education programs and activities receiving Federal financial assistance (whether or not the programs or activities are offered or sponsored by an educational institution); and

(5)USAID regulations implementing the above nondiscrimination laws, set forth in Chapter II of Title 22 of the Code of Federal Regulations.

(b)If the applicant/grantee is an institution of higher education, the Assurances given herein extend to admission practices and to all other practices relating to the treatment of students or

clients of the institution, or relating to the opportunity to participate in the provision of services or other benefits to such individuals, and shall be applicable to the entire institution unless the applicant/grantee establishes to the satisfaction of the USAID Administrator that the institution's practices in designated parts or programs of the institution will in no way affect its practices in the program of the institution for which financial assistance is sought, or the beneficiaries of, or participants in, such programs.
(c)This assurance is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts, or other Federal financial assistance extended after the date hereof to the applicant/grantee by the Agency, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The applicant/grantee recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance, and that the United States shall

have the right to seek judicial enforcement of this Assurance. This Assurance is binding on the applicant/grantee, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the applicant/grantee.

2.CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

(a)Instructions for Certification

(1)By signing and/or submitting this application or grant, the applicant/grantee is providing the certification set out below.

(2)The certification set out below is a material representation of fact upon which reliance was placed when the agency determined to award the grant. If it is later determined that the applicant/grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, the agency, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

(3)For applicants/grantees other than individuals, Alternate I applies.

(4)For applicants/grantees who are individuals, Alternate II applies.

(b)Certification Regarding Drug-Free Workplace Requirements

Alternate I

(1)The applicant/grantee certifies that it will provide a drug-free workplace by:

(A)Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the applicant's/grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(B)Establishing a drug-free awareness program to inform employees about--

1.The dangers of drug abuse in the workplace;

2.The applicant's/grantee's policy of maintaining a drug-free workplace;

3.Any available drug counseling, rehabilitation, and employee assistance programs; and

4.The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(C)Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (b)(1)(A);

(D)Notifying the employee in the statement required by paragraph (b)(1)(A) that, as a condition of employment under the grant, the employee will--

1.Abide by the terms of the statement; and

2.Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

(E)Notifying the agency within ten days after receiving notice under subparagraph (b)(1)(D)1. from an employee or otherwise receiving actual notice of such conviction;

(F)Taking one of the following actions, within 30 days of receiving notice under subparagraph (b)(1)(D)2., with respect to any employee who is so convicted--

1.Taking appropriate personnel action against such an employee, up to and including termination; or

2.Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(G)Making a good faith effort to continue to maintain a drug-free

workplace through implementation of paragraphs (b)(1)(A), (b)(1)(B), (b)(1)(C), (b)(1)(D), (b)(1)(E) and (b)(1)(F).

(2)The applicant/grantee shall insert in the space provided below the site(s) for the performance of work done in connection with the specific grant:

Place of Performance (Street address, city, county, state, zip code)

Alternate II

The applicant/grantee certifies that, as a condition of the grant, he or she will not engage in the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance in conducting any activity with the grant.

3.CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS -- PRIMARY COVERED TRANSACTIONS

(a)Instructions for Certification

1.By signing and submitting this proposal, the prospective primary participant is providing the certification set out below.

2.The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. The prospective participant shall submit an explanation of why it cannot provide the certification set out below. The certification or explanation will be considered in connection with the department or agency's determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3.The certification in this clause is a material representation of fact upon which reliance was placed when the department or agency determined to enter into this transaction. If it is later

determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default.

4.The prospective primary participant shall provide immediate written notice to the department or agency to whom this proposal is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5.The terms "covered transaction," "debarred," "suspended," "ineligible," lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meaning set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549. You may contact the department or agency to which this proposal is being submitted for assistance in obtaining a copy of those regulations.

6.The prospective primary participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency entering into this transaction.

7.The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," provided by the department or agency entering into this covered transaction, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8.A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the methods and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.

9.Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealing.

10.Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is

suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default.

(b)Certification Regarding Debarment, Suspension, and Other Responsibility Matters--Primary Covered Transactions

(1)The prospective primary participant certifies to the best of its knowledge and belief, the it and its principals:

(A)Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;

(B)Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(C)Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(B) of this certification;

(D)Have not within a three-year period proceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

(2)Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

4.CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1)No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement.

(2)If any funds other than Federal appropriated funds have been

paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3)The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, United States Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

5.AGREEMENT ON GRANT TERMS AND CONDITIONS

The applicant/grantee certifies that it has reviewed and is familiar with the proposed grant format and the standard provisions applicable thereto, and that it agrees to comply with all such terms and conditions, except as noted below (use a continuation page as necessary):

Solicitation No.

Application/Proposal No.

Date of Application/Proposal

Name of Applicant/Grantee

Typed Name and Title

Signature

Date